

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09049

9078

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick City</u>	c. LENGTH OF STAY IN 1b <u>2 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster RD # 7</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Frederick Memorial Hosp</u>		d. STREET ADDRESS <u>Pleasant Valley</u>	
3. NAME OF DECEASED (Type or print) First <u>Gary H.</u> Middle <u>Angell</u> Last <u>Angell</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>10</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 22, 1888</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Carroll Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Charles W. Angell</u>		14. MOTHER'S MAIDEN NAME <u>Mary A. Kemper</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-46-0690</u>	
17. INFORMANT <u>Mrs Stanley M. Beaver</u>		Address <u>Westminster, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardiovascular Disease Syst</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/9</u> , 19 <u>59</u> , to <u>8/10</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>8/10</u> , 19 <u>59</u> , and that death occurred at <u>11:45 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Henry V. Chase</u> M.D.		ADDRESS (Street, city or town, state) <u>4 E. Church St</u> DATE SIGNED <u>8/11/59</u>	
PHYSICIAN'S NAME (Type) <u>Henry V. Chase</u>		<u>Frederick Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 13, 59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Valley</u>		22d. LOCATION (City, town, or county) (State) <u>Westminster Md RD # 7</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>S. E. Myers, Jr.</u>		ADDRESS <u>Westminster Md</u>	
24a. REC'D BY REGISTRAR <u>AUG 14 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>	



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VS A15 (4)  
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9114

CERTIFICATE OF DEATH

09050

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodsboro</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>H.</u> Middle <u>Lamar</u> Last <u>Barrick</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>22</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 14, 1898</u>
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self-Barrick Sons, Lime mfgs.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Barrick</u>		14. MOTHER'S MAIDEN NAME <u>Laura P. Long</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>217-03-5377</u>	
17. INFORMANT <u>Mrs. Margaret Barrick</u>		Address <u>Woodsboro Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CORONARY THROMBOSIS</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>Few minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec. 21</u> , 1958, to <u>Aug. 22</u> , 1959, that I last saw the deceased alive on <u>Feb. 26</u> , 1959, and that death occurred at <u>4:15 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ernest A. Dettbarn</u> M.D.		ADDRESS (Street, city or town, state) <u>Walthamville, Md.</u> DATE SIGNED <u>Aug 22/59</u>	
PHYSICIAN'S NAME (Type) <u>ERNEST A. DETTBARN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug. 24, '59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt Hope</u>	22d. LOCATION (City, town, or county) (State) <u>Woodsboro Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Byron E. Heston</u>		24a. REC'D BY REGISTRAR <u>AUG 26 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Heston</u>			

CERTIFICATE OF DEATH

I hereby certify that the above is a true and correct statement of the facts as they came to my knowledge and belief.		I hereby certify that the above is a true and correct statement of the facts as they came to my knowledge and belief.	
Signature of Registrar		Signature of Physician	
Date		Date	
Place		Place	
Name of Deceased		Name of Deceased	
Age		Age	
Sex		Sex	
Race		Race	
Occupation		Occupation	
Cause of Death		Cause of Death	
Date of Death		Date of Death	
Place of Death		Place of Death	
Name of Hospital		Name of Hospital	
Name of Physician		Name of Physician	
Name of Registrar		Name of Registrar	

This certificate is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, and a copy thereof to be sent to the local health officer of the city or county in which the death occurred.

9079

CERTIFICATE OF DEATH

Reg. Dist. No.

09051

1. PLACE OF DEATH a. COUNTY <i>Fredericks</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Carroll</i> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Fredericks City</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural, Westminster</i> 06x-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Fredericks Memorial Hospital</i>		d. STREET ADDRESS <i>Gambier</i>	
3. NAME OF DECEASED (Type or print) First <i>Phillip</i> Middle <i>Lee</i> Last <i>Beamer</i>		4. DATE OF DEATH Month <i>Aug.</i> Day <i>8</i> Year <i>1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 19 1895</i> 63 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Combustion Engineer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
11. BIRTHPLACE (State or foreign country) <i>Torrey Gap, Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Alphonso Beamer</i>		14. MOTHER'S MAIDEN NAME <i>Cola Combs</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO. <i>230-03-1520</i>	
17. INFORMANT <i>Mr. P.L. Beamer, Westminster, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Coronary Thrombosis</i> 420.0 DUE TO (b) <i>Anteroselective Heart Disease</i> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <i>2 WKS</i> <i>5 yrs +</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>7/27</i> , 19 <i>59</i> , to <i>8/8</i> , 19 <i>59</i> , that I lost saw the deceased alive on <i>8/8</i> , 19 <i>59</i> , and that death occurred at <i>10:30</i> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Henry V Chase</i> M.D.		ADDRESS (Street, city or town, state) <i>4 E. Church St</i> DATE SIGNED <i>8/9/59</i>	
PHYSICIAN'S NAME (Type) <i>Henry V. Chase</i>		<i>Frederick Md</i>	
22a. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Aug. 11, 59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Westminster Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Westminster Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. E. Myers, Jr.</i> ADDRESS <i>Westminster, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>AUG 12 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. House</i>

MEDICAL CERTIFICATION

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9080

## CERTIFICATE OF DEATH

09052

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN TB <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>		e. STREET ADDRESS <b>352 Madison Street</b>	
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>DeWITT</b> Last <b>BIGGS</b>		4. DATE OF DEATH Month <b>August</b> Day <b>12</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>21 Dec 1891</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Finisher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Brush Company</b>	11. BIRTHPLACE (State or foreign country) <b>Frederick, Md.</b>
13. FATHER'S NAME <b>E. H. Biggs</b>		14. MOTHER'S MAIDEN NAME <b>Clara Nusz</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> <b>WWI</b>		16. SOCIAL SECURITY NO. <b>214-10-1796</b>	
17. INFORMANT <b>Mrs. Grace R. Biggs (Same as item #2)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho pneumonia</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterio sclerosis</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>2 yrs +</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>July</b> 19 <b>40</b> , to <b>Aug 12</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Aug 12</b> , 19 <b>59</b> , and that death occurred at <b>10:40 A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>B. O. Thomas</b>		ADDRESS (Street, city or town, state) <b>228 N. Market St.</b> DATE SIGNED <b>14 Aug 1959</b>	
PHYSICIAN'S NAME (Type) <b>B. O. Thomas, M. D.</b>		Frederick, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8-17-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Ft. Myer, Va.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Md.</b>		ADDRESS <b>Frederick, Md.</b>	
24a. REC'D BY REGISTRAR <b>AUG 17 59</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton L. Frank</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





Frederick

Frederick

ON A FARM?  
YES ☐ NO ☒

Month	Day	Year
August	22.	1959

Months	Days	Hours	Min.
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USA

Sarah Lease

Miss Edna I. Bopst (Same as item #1)

INTERVAL BETWEEN ONSET AND DEATH

arterio Sclerose

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(d)

19. WAS AUTOPSY PERFORMED?  
YES ☐ NO ☒

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 1B.)

(State)

**ADDRESS** (Street, city or town, state)

24 Aug 1959

Frederick, Md.

Frederick, Maryland

DATE AUG 27 '59

October 9 1954

CERTIFICATE OF DEATH

1901

NAME

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

RESIDENCE

DATE OF DEATH  
PLACE OF DEATH  
CAUSE OF DEATH  
MANNER OF DEATH  
SIGNATURE OF DECEASED  
SIGNATURE OF WITNESSES  
SIGNATURE OF MINISTER OF THE GOSPEL  
SIGNATURE OF JUDGE OF THE COURT  
SIGNATURE OF CLERK OF THE COURT  
SIGNATURE OF SHERIFF OF THE COUNTY  
SIGNATURE OF TOWNSHIP CLERK  
SIGNATURE OF COUNTY CLERK  
SIGNATURE OF STATE CLERK  
SIGNATURE OF U.S. MARSHAL  
SIGNATURE OF U.S. ATTORNEY  
SIGNATURE OF U.S. DISTRICT JUDGE  
SIGNATURE OF U.S. SUPREME COURT JUSTICE  
SIGNATURE OF U.S. SENATOR  
SIGNATURE OF U.S. REPRESENTATIVE  
SIGNATURE OF GOVERNOR  
SIGNATURE OF VICE PRESIDENT  
SIGNATURE OF PRESIDENT

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 9082 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09054

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>			c. LENGTH OF STAY IN 1b <b>Years</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Frederick Memorial Hospital</b>				d. STREET ADDRESS <b>242 East Seventh Street</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>CORA</b> Middle <b>JANE</b> Last <b>BURNS</b>				4. DATE OF DEATH Month <b>August</b> Day <b>7</b> Year <b>19 59</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4 Dec 1883</b>	
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Sewing Factory Employee</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>		11. BIRTHPLACE (State or foreign country) <b>USA</b>	
13. FATHER'S NAME <b>Julius Watkins</b>				14. MOTHER'S MAIDEN NAME <b>Amanda (Last Name Unknown)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-10-3037</b>		17. INFORMANT Address <b>Mrs. Billie D. Burns (Same as item #2)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fracture base of Skull</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>3 hrs.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Jumped out of attic window</b>					
20c. TIME OF INJURY Month, Day, Year Hour <b>3</b> m. <b>8 17 59</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Frederick Frederick Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>B O Thomas</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>B. O. Thomas, M. D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>9 Aug 1959</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-10-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Bethesda Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Browningsville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				ADDRESS		24a. REC'D BY REGISTRAR DATE <b>AUG 11 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hana</b>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MISSOURI STATE DEPARTMENT OF HEALTH - BATHING IN  
 3082 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
John Doe		Male		45		Jan 15, 1950	
Place of Birth		Usual Residence		Cause of Death		Manner of Death	
St. Louis, Mo.		St. Louis, Mo.		Heart Disease		Natural	
Occupation		Education		Previous Illnesses		Drugs Taken	
Teacher		High School		Hypertension		None	
Signature of Examiner		Signature of Physician		Signature of Coroner		Signature of Registrar	
[Signature]		[Signature]		[Signature]		[Signature]	
Date of Examination		Time of Examination		Place of Examination		Witnesses	
Jan 15, 1950		10:00 AM		St. Louis, Mo.		John Smith, Mary Jones	

RECEIVED  
 JAN 16 1950  
 MISSOURI STATE DEPARTMENT OF HEALTH

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9083

## CERTIFICATE OF DEATH

09055

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>FREDERICK</u> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u>				c. LENGTH OF STAY IN 1b <u>4 DAYS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MT. AIRY, ROUTE #1, MARYLAND</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FREDERICK MEMORIAL HOSPITAL</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>EVERTT</u> Middle <u>G.</u> Last <u>CASHOUR</u>				<b>4. DATE OF DEATH</b> Month <u>AUGUST</u> Day <u>28</u> Year <u>1959</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-4-1982</u>	
9. AGE (In years last birthday) yrs. <u>77</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired farmer</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>farmer</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>ALBERT CASHOUR</u>	
14. MOTHER'S MAIDEN NAME <u>IDA BUTTS</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>218-10-8535</u>		17. INFORMANT <u>HOSPITAL RECORDS</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sub arachnoid Hemorrhage</u> <u>330X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>AUG. 24</u> , 19 <u>59</u> , to <u>AUG. 28</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>AUGUST 28</u> , 19 <u>59</u> , and that death occurred at <u>6:35 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard C. Reynolds</u> M.D.		ADDRESS (Street, city or town, state) <u>9 E. Church St Frederick, Maryland</u>		DATE SIGNED <u>8/28/59</u>			
PHYSICIAN'S NAME (Type) <u>RICHARD C. REYNOLDS</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>					
22b. DATE THEREOF <u>AUG 31 '59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CENTRAL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>NEAR NEW LONDON MD</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lucian K. Falconer</u>		ADDRESS <u>New Market MD</u>		24a. REC'D BY REGISTRAR <u>SEP 1 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	



CERTIFICATE OF DEATH

0083

NAME OF DECEASED <i>Richard C. Newman</i>		DATE OF DEATH <i>10-17-1922</i>	
AGE <i>34</i>		SEX <i>M</i>	
RACE <i>W</i>		RELIGION <i>Catholic</i>	
MARRIED <i>Yes</i>		OCCUPATION <i>None</i>	
PLACE OF BIRTH <i>St. Louis, Mo.</i>		PLACE OF DEATH <i>Baltimore, Md.</i>	
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>	
SIGNATURE OF PHYSICIAN <i>Richard C. Newman</i>		SIGNATURE OF WITNESSES <i>Richard C. Newman</i>	
DATE <i>10-17-1922</i>		PLACE <i>Baltimore, Md.</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9115

## CERTIFICATE OF DEATH

Reg. Dist. No.

09056

Items 22 a, b, c & d, Film C246 8/6/59 JWK

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cullen</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Rainier</u> 16-16-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Victor Cullen State Hospital</u>		d. STREET ADDRESS <u>3500 Perry St</u>	
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Cochran</u> Last <u>Cochran</u>		4. DATE OF DEATH Month <u>August</u> Day <u>2</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-15-1886</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Finance</u>	
11. BIRTHPLACE (State or foreign country) <u>Alabama</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Edward Cochran</u>		14. MOTHER'S MAIDEN NAME <u>Annie Shields</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Record of Victor Cullen State Hospital</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Tuberculosis</u> <u>002X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>8/1</u> 19 <u>59</u> , to <u>8/2</u> 19 <u>59</u> , that I last saw the deceased alive on <u>8/1</u> 19 <u>59</u> , and that death occurred at <u>2:45</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>T.F. Vestal</u>		ADDRESS (Street, city or town, state) <u>Cullen, Md</u>	
PHYSICIAN'S NAME (Type) <u>Thomas F. Vestal</u>		DATE SIGNED <u>Victor Cullen Hospital Cullen, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/4/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Hyattsville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>M. J. (Cochran) &amp; Son</u>		24a. REC'D BY REGISTRAR <u>AUG 4 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			



9084

## CERTIFICATE OF DEATH

09057

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>7½ Hours</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick County Chronic Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ARTHUR</b> Middle <b>HAYES</b> Last <b>CROMWELL</b>				4. DATE OF DEATH Month <b>August</b> Day <b>27</b> , Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 3, 1877</b>		9. AGE (In years last birthday) yrs. <b>81</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farming</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farmer</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Arthur Cromwell</b>				14. MOTHER'S MAIDEN NAME <b>Christiana W. Trundle</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT Address <b>Mr. Richard Cromwell, Dickerson, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aortic Stenosis</b> <b>411x</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>Cardio Vascular Disease</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b> <b>10 Years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 3, 1943</b> to <b>Aug 27, 1959</b> , that I last saw the deceased alive on <b>Aug 26, 1959</b> , and that death occurred at <b>12:05 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>B. O. Thomas</b>		M.D. <b>Professional Building</b>		DATE SIGNED <b>8/27/59</b>			
PHYSICIAN'S NAME (Type) <b>B. O. Thomas, M. D.</b>		Frederick, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 29, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				ADDRESS		24a. REC'D BY REGISTRAR DATE <b>AUG 31 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





9085

CERTIFICATE OF DEATH

Reg. Dist. No.

09058

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>hours</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Frederick Memorial Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Thomas</b> Last <b>Davis</b>				4. DATE OF DEATH Month <b>8</b> Day <b>6</b> Year <b>1959</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/20/1900</b>	9. AGE (In years lost birthday) <b>59</b> yrs.	IF UNDER 1 YEAR Months <b>5</b> Days <b>10</b> Hours <b>15</b> Min.	IF UNDER 24 HRS. Months <b>5</b> Days <b>10</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>office worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>government</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Jefferson Davis</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Stewart</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Herbert F. Davis, Middletown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio Sclerosis</b> DUE TO (c) <b>Arterio Sclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug 3, 1959</b> , to <b>Aug 6, 1959</b> , that I last saw the deceased alive on <b>Aug 6, 1959</b> , and that death occurred at <b>8:15 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Elmer Harp</b> M.D.				ADDRESS (Street, city or town, state) <b>Middletown 8-7-59</b> DATE SIGNED <b>Maryland</b>			
PHYSICIAN'S NAME (Type) <b>ELMER HARP</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>8/8/1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Green M.E. Cemetery Bel Air, Maryland</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Gladhill Company, Middletown, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>AUG 10 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



9085

## CERTIFICATE OF DEATH

09059

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Crown</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN lb <b>1 week</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Rosenia W.</b> Middle <b>Eiler</b> Last		4. DATE OF DEATH Month <b>Aug/</b> Day <b>11</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 25, 1915</b>
9. AGE (In years last birthday) <b>44</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Howard Willard</b>	
14. MOTHER'S MAIDEN NAME <b>Mary K. Brown</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT <b>Charles M. Eiler</b> Address <b>Union Bridge RD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronche pneumonia</b> <b>757.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Polycystic Kidneys</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>10 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Sept</b> , 1950, to <b>Aug 11</b> , 1959, that I last saw the deceased alive on <b>Aug 10</b> , 1959, and that death occurred at <b>7-10</b> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>228 N. Market St. Fred.</b> DATE SIGNED <b>8/13/59</b> ACTUAL SIGNATURE <b>L. R. Schoolman</b> M.D. PHYSICIAN'S NAME (Type) <b>L.R. Schoolman</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8-14-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Blue Ridge Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Thurmont, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Creager</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 17 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>

1

Page 4

death. Pages 1 and 2 should be filled with the funeral director, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

CERTIFICATE OF DEATH

0087

Decedent's Name: Frederick A. Scholman  
Age: 1 week  
Sex: Male  
Race: Jewish

Place of Death: Memorial Hospital

Decedent's Address: 100 N. 1st St., Philadelphia, Pa.

X

Signature of Physician: [Signature]

Signature of Registrar: [Signature]

Signature of Burial Officer: [Signature]

Signature of Undertaker: [Signature]

100

100 N. 1st St., Philadelphia, Pa.

100

100 N. 1st St., Philadelphia, Pa.

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9116

## CERTIFICATE OF DEATH

09060

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Frederick</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Frederick</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Rural--Mt. Airy</b>		LENGTH OF STAY (In this place) <b>life</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Rural--Mt. Airy</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <b>JOHN</b>		(Middle) <b>V.</b>		(Last) <b>FOX</b>		(Month) (Day) (Year) <b>AUG. 9, 1959</b>	
<b>5. SEX</b> <b>male</b>	<b>6. COLOR OR RACE</b> <b>white</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED,</b> <b>widowed</b>	<b>8. DATE OF BIRTH</b> <b>10-19-1882</b>		<b>9. AGE last birthday</b> <b>76</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Carpenter, retired</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>general</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.</b>	
<b>13. FATHER'S NAME</b> <b>Howard Fox</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Katie Swomley</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b> <b>219-20-2396</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Mrs. Paul Tressler, same</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>423.2 IMMEDIATE CAUSE (A)</b>				<b>Myocardial Degeneration</b>			
<b>ANTECEDENT CAUSE(S) DUE TO</b>				<b>Chronic Myocarditis</b>			
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE</b>							
<b>STATING UNDERLYING CAUSE LAST.</b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from 7-26-1959, to 8-8-1959, that I last saw the deceased alive on 8-8-1959, and that death occurred at 5 A.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>J. H. Legg</i> M.D.				<b>ADDRESS</b> (Street, city, town, state) <i>Merison Bridge Md 289-59</i>		<b>DATE SIGNED</b> <i>8-8-59</i>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>BURIAL</b>		<b>DATE THEREOF</b> <b>8-11-1959</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Libertytown, Md.</b>		<b>LOCATION (City, town, or county) (State)</b>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <i>Charles L. Evans</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>C. M. Waltz, Winfield, Md.</b>		<b>ADDRESS</b>	
<b>DATE</b> <b>AUG 12 '59</b>							





9087

Item 1 Film G246 8-11-59 et

**CERTIFICATE OF DEATH**

09061

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>3 weeks</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>109 Water St. Private home</b>				d. STREET ADDRESS <b>Route # 1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>STELLA</b> Middle <b>MAE</b> Last <b>GOUKER</b>				4. DATE OF DEATH Month <b>August</b> Day <b>5</b> Year <b>1959</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 7, 1879</b>	
9. AGE (In years lost birthday) <b>80</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Frederick Co. Md.</b>	
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Manassas Rice</b>				14. MOTHER'S MAIDEN NAME <b>Nancy Ambrose</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mr. E. B. Gouker, Myersville, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>hypertensive Cardio-Vascular disease</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) <b>Frederick, Md.</b>		(County) (State)	
21. I certify that I attended the deceased from <b>April 10, 1954</b> to <b>Aug 5, 1959</b> , that I last saw the deceased alive on <b>Aug 4, 1959</b> , and that death occurred at <b>6:45 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Bernard O. Thomas Jr.</b> M.D.				ADDRESS (Street, city or town, state) <b>Frederick, Md.</b> DATE SIGNED <b>8/5/59</b>			
PHYSICIAN'S NAME (Type) <b>Bernard O. Thomas Jr.</b>				<b>Frederick, Md.</b>			
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 7, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. John's Lutheran</b>		22d. LOCATION (City, town, or county) (State) <b>Nr. Myersville, Fred. Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Paul F. Bittle</b>				ADDRESS <b>Myersville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 7 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Frank</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9111

CERTIFICATE OF DEATH

Reg. Dist. No.

09062

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brunswick</b>				c. LENGTH OF STAY IN 1b <b>30 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>North Virginia Avenue</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Charles David Green</b>				4. DATE OF DEATH Month Day Year <b>8 - 1 1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>1-10-1895</b>	
9. AGE (In years last birthday) yrs. <b>64</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Car man</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>David Clinton Green</b>				14. MOTHER'S MAIDEN NAME <b>Margareto</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes World I</b>				16. SOCIAL SECURITY NO. <b>Clyde Green, Brunswick, Maryland.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Rheumatism</b> DUE TO (c) <b>Septic Throat</b> INTERVAL BETWEEN ONSET AND DEATH <b>June 1963</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <b>6/11</b> , 19 <b>59</b> to <b>8/1</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>7/17</b> , 19 <b>59</b> , and that death occurred at <b>7 A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>[Signature]</b> M.D.				ADDRESS (Street, city or town, state) <b>Brunswick, Maryland.</b> DATE SIGNED <b>8/1/59</b>			
PHYSICIAN'S NAME (Type) <b>J.G.F. Smith</b>				Brunswick, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-4-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Marks Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Petersville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>[Signature]</b> ADDRESS <b>Brunswick, Maryland.</b>				24a. REC'D BY REGISTRAR DATE <b>AUG 5 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

CERTIFICATE OF DEATH

9141

1-20-1904

1-20-1904

1-20-1904

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9088

CERTIFICATE OF DEATH

09063

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>32 Years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>112 West Patrick Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>GHERMAN</b> Middle <b>BENSON</b> Last <b>HAINES</b>				4. DATE OF DEATH Month <b>August</b> Day <b>18</b> , Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 24, 1883</b>	
9. AGE (In years last birthday) <b>75</b> yrs.		10. UNDER 1 YEAR Months <b>10</b> Days <b>20</b> Hours <b>20</b> Min.		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>			
13. FATHER'S NAME <b>George H. Haines</b>				14. MOTHER'S MAIDEN NAME <b>Minnie Runkles</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>215-26-8336</b>			
17. INFORMANT <b>Mrs. Nellie H. Haines-Same as Item #2</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cardiac Congestion</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>Cardiovascular diseases</b> DUE TO (c) <b>107.20</b>				INTERVAL BETWEEN ONSET AND DEATH <b>Home</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>June</b> , 19 <b>45</b> to <b>Aug 18</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Aug 17</b> , 19 <b>59</b> , and that death occurred at <b>80</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Professional Building</b> DATE SIGNED <b>8/18/1959</b> ACTUAL SIGNATURE <b>B. O. Thomas</b> M.D. <b>Frederick, Maryland</b> PHYSICIAN'S NAME (Type) <b>B. O. Thomas, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>Aug. 21, 1959</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>				22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>AUG 20 '59</b>			
24b. REGISTRAR'S SIGNATURE <b>Clair &amp; Thomas</b>							

90003

CERTIFICATE OF DEATH

90002



*[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. The text appears to be organized into sections, possibly containing names, dates, and addresses.]*

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

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X

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
9117 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09064

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sabillasville rural</b>		c. LENGTH OF STAY IN 1b <b>Lifetime</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sabillasville rural</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Edgar Hamilton Harbaugh</b>		4. DATE OF DEATH Month Day Year <b>August 16 1959</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 24, 1905</b>
9. AGE (In years last birthday) <b>54</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Martin Harbaugh</b>		14. MOTHER'S MAIDEN NAME <b>Mary B. Harbaugh</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>814-32-4421</b>	
17. INFORMANT <b>Mrs. Grace P. Harbaugh</b>		Address <b>Md. Sabillasville</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gun Shot wound left chest</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shot Self in left chest</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>3 8/16 1959</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Sabillasville Frederick Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>B.O. Thomas</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>B.O. Thomas</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>August 16, 1959</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-19-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Blue Ridge Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Thurmont, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Croager</b>		ADDRESS <b>Thurmont, Md.</b>	
24a. REC'D BY REGISTRAR <b>AUG 20 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>	

MEDICAL CERTIFICATION

2

BP

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1000

© 2000 by John Wiley & Sons, Inc.

10/10/11 10:10:11

Estimated 1970-1971

42

1001 4th Ave. S. 1001

OS LAW

反人新劇

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Open Access

Marvin J. Long

Walters, E. 1964

1911

They won't, though.

1895-1900

— 918 —

THE FRONT

TEST • ANSWERS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
9089  
CERTIFICATE OF DEATH

09065

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Potomac</b> 15X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>		d. STREET ADDRESS <b>Rockville, Maryland</b>	
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>M</b> Last <b>HARRIS</b>		4. DATE OF DEATH Month <b>August</b> Day <b>13</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/16/1873</b>
9. AGE (In years last birthday) <b>86</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>6</b> Days <b>27</b> Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U/S</b>	
13. FATHER'S NAME <b>James Harris</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>J. Frank Harris-son-same as item 2d</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Probable Carcinoma of Intestine -</b> <b>153.9</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Intestinal Obstruction</b> DUE TO (c) <b>Advanced Arterio Sclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug 12, 1959</b> , to <b>Aug 13, 1959</b> , that I last saw the deceased alive on <b>Aug 13, 1959</b> , and that death occurred at <b>4:45 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Elmer Harp</b> M.D.		ADDRESS (Street, city or town, state) <b>Middletown Md</b> DATE SIGNED <b>8-13-59</b>	
PHYSICIAN'S NAME (Type) <b>ELMER HARP</b>		<b>Middletown Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8/15/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Potomac Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Potomac, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphery</b>		ADDRESS <b>Bethesda, Maryland</b>	
24a. REC'D BY REGISTRAR <b>AUG 17 59</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton S. Harris</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9090

## CERTIFICATE OF DEATH

Reg. Dist. No.

09066

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN lb <b>15 Days</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick-Rural RD#7</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Frederick Memorial Hospital</b>				d. STREET ADDRESS <b>Yellow Springs</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>SHERWOOD</b> Middle <b>LURINE</b> Last <b>HARRIS</b>				4. DATE OF DEATH Month <b>August</b> Day <b>10</b> Year <b>19 59</b>							
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1 May 1906</b>		9. AGE (In years last birthday) yrs. <b>53</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Emma Harris</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>214-10-2285</b>		17. INFORMANT <b>Mrs. Beatrice L. Harris (Same as item #2)</b>				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchial Pneumonia</b> <b>153.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Post-operative ileus + peritonitis</b> DUE TO (c) <b>Resection of descending colon</b> INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs</b> <b>8 days</b> <b>10 days</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma of descending colon with metastases</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>July 26</b> , 19 <b>59</b> , to <b>Aug 10</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Aug 10</b> , 19 <b>59</b> , and that death occurred at <b>2:35 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>15 E. Second St.</b> DATE SIGNED <b>8-10-59</b> ACTUAL SIGNATURE <b>John M. Culler</b> M.D. PHYSICIAN'S NAME (Type) <b>John M. Culler, M. D.</b> <b>Frederick, Md.</b>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>8-13-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Brook Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Yellow Springs, Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>						ADDRESS		24a. REC'D BY REGISTRAR DATE <b>AUG 13 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Harris</b>	

02692

3304

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Middletown</b>		c. LENGTH OF STAY IN 1b <b>months</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Valley View Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Walter H.</b> Middle <b>Heffner</b> Last		4. DATE OF DEATH Month <b>8</b> Day <b>27</b> Year <b>1959</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/29/1889</b>
9. AGE (In years last birthday) yrs. <b>70</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>coal dealer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>coal</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>John Heffner</b>		14. MOTHER'S MAIDEN NAME <b>Sally Staley</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>217-32-5684</b>	
17. INFORMANT <b>Mrs. Blanche Heffner</b>		Address <b>Frederick, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>332x Cerebral Thrombosis</b> DUE TO (b) <b>Arterio-sclerotic C.V. Disease</b> DUE TO (c) <b>surgical removal right lung</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>54 years</b> <b>2 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 1, 1959</b> , to <b>Aug. 27, 1959</b> , that I last saw the deceased alive on <b>Aug. 26, 1959</b> , and that death occurred at <b>6:30 AM</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Bernard Thomas, Jr.</b> M.D.		ADDRESS (Street, city or town, state) <b>Frederick, Md.</b> DATE SIGNED <b>8/28/59</b>	
PHYSICIAN'S NAME (Type) <b>Dr. B. O. Thomas, Jr.</b>		<b>Frederick, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>8/29/1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Lutheran Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Middletown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Gladhill Company, Middletown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 1 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Carlton S. Hines</b>			

CERTIFICATE OF DEATH

DECEASED

AT HOME

DATE

PLACE

CAUSE

AGE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

AGE

CAUSE

DATE

PLACE

DATE

PLACE

SIGNED AND SEALED AT THE CITY OF NEW YORK, THIS 10TH DAY OF JANUARY, 1901.

ATTEST: I, the undersigned, being a duly qualified Registrar of Deaths for the City of New York, do hereby certify that the foregoing is a true and correct copy of the original record on file in my office.

GIVEN UNDER MY HAND AND SEAL OF OFFICE, IN THE CITY OF NEW YORK, THIS 10TH DAY OF JANUARY, 1901.

REGISTRAR OF DEATHS.

WITNESSES: I, the undersigned, being a duly qualified Registrar of Deaths for the City of New York, do hereby certify that the foregoing is a true and correct copy of the original record on file in my office.

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REGISTRAR OF DEATHS.

WITNESSES: I, the undersigned, being a duly qualified Registrar of Deaths for the City of New York, do hereby certify that the foregoing is a true and correct copy of the original record on file in my office.

GIVEN UNDER MY HAND AND SEAL OF OFFICE, IN THE CITY OF NEW YORK, THIS 10TH DAY OF JANUARY, 1901.



9119

## CERTIFICATE OF DEATH

09068

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Frederick</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutions: Residence before admision) o. STATE <i>Maryland</i> b. COUNTY <i>Frederick</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>R#7</i>				c. LENGTH OF STAY IN 1b <i>59 days</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Frederick County Chronic Hosp.</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Daniel</i> Middle <i>Lee</i> Last <i>Himes</i>				4. DATE OF DEATH Month <i>8</i> Day <i>28</i> Year <i>1959</i>			
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>8/15/75</i>	
9. AGE (In years last birthday) <i>84</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Church sexton</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>		11. BIRTH PLACE (State or foreign country) <i>Frederick Co., Maryland</i>	
13. FATHER'S NAME <i>Mr. John N. Himes</i>				14. MOTHER'S MAIDEN NAME <i>Sarah Stine</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>214-10-5916</i>		17. INFORMANT <i>Ruth Crawford Rm. Supt. Frederick County Chronic Hosp</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma Rem</i> <i>156X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Generalized abdominal metastases</i> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <i>1 yr.</i> <i>1 yr.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>7/11/59</i> to <i>Aug 27, 1959</i> , that I last saw the deceased alive on <i>Aug 27, 1959</i> , and that death occurred at <i>7:50 PM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>71 N. Market St. Frederick Md</i> DATE SIGNED <i>Aug 27 1959</i>							
ACTUAL SIGNATURE <i>H. F. Kline</i> PHYSICIAN'S NAME (Type) <i>H. F. KLINE</i>				M.D. <i>Frederick Md.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>August 31, '59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Frederick Memorial Park</i>		22d. LOCATION (City, town, or county) (State) <i>Frederick, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert C. Dailey</i> ADDRESS <i>Frederick, Maryland</i>				24a. REC'D BY REGISTRAR DATE <i>AUG 31 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9120

CERTIFICATE OF DEATH

09069

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Middletown</b>				c. LENGTH OF STAY IN 1b <b>years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Annie C. C.</b> Middle <b>Holter</b> Last				4. DATE OF DEATH Month <b>8</b> Day <b>31</b> Year <b>1959</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/20/1884</b>	
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>Daniel L. Bussard</b>				14. MOTHER'S MAIDEN NAME <b>Mary M. Cline</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>none</b>			
INFORMANT <b>Amos A. Holter, Middletown, Md.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>Coronary Sclerosis</b> (c) <b>Hypertension C.V. Disease</b> INTERVAL BETWEEN ONSET AND DEATH <b>10 mo</b> <b>10 yrs</b> <b>20 yrs</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>June</b> , 19 <b>52</b> , to <b>Aug 31</b> , 19 <b>59</b> that I last saw the deceased alive on <b>Aug 6</b> , 19 <b>59</b> , and that death occurred at <b>3A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Jefferson Md</b> DATE SIGNED <b>8/31/59</b>							
ACTUAL SIGNATURE <b>A. V. Brice</b> M.D.				PHYSICIAN'S NAME (Type) <b>Dr. A. Talbott Brice</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>				22b. DATE THEREOF <b>9/2/1959</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Reformed Cemetery</b>				22d. LOCATION (City, town, or county) (State) <b>Middletown, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Gladhill Company, Middletown, Md.</b>				24a. REC'D BY REGISTRAR <b>8 '59</b> 24b. REGISTRAR'S SIGNATURE <b>Christina L. Harris</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages remove certain papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

9120



MEMORANDUM FOR THE DIRECTOR

TO : SAC, NEW YORK (100-100000)

FROM : SAC, NEW YORK (100-100000)

SUBJECT: [Illegible]

RE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 9091

### CERTIFICATE OF DEATH

09070

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Fred.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Fred.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>			
c. LENGTH OF STAY IN 1b <u>5 WKS</u>				d. STREET ADDRESS <u>117 East St.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick-Memorial-Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Carrie</u> Middle <u>Jackson</u> Last <u>Jones</u>				4. DATE OF DEATH Month <u>Aug.</u> Day <u>31</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 28-56</u>		9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Fred. Co. Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Jackson</u>				14. MOTHER'S MAIDEN NAME <u>Cornelia Dicks</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>520-18-1684D</u>		17. INFORMANT <u>D. Williams-117 East</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastro-intestinal hemorrhage</u> DUE TO <u>153.8</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>? Malignancy of colon</u> DUE TO <u></u> (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>hours</u> <u>? months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>8/1</u> , 1959, to <u>8/31</u> , 1959, that I last saw the deceased alive on <u>8/30</u> , 1959, and that death occurred at <u></u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>James B. Thomas</u> M.D.				PHYSICIAN'S NAME (Type) <u>James B. Thomas Frederick-Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-3-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hope Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Fred. Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. Hicks</u> ADDRESS <u>Fred. Md.</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 9 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Caroline E. Frank</u>	



CERTIFICATE OF DEATH

0007

<p>1. NAME OF DECEASED  <i>William J. Williams</i></p>		<p>2. SEX  <i>Male</i></p>		<p>3. AGE  <i>35</i></p>	
<p>4. DATE OF DEATH  <i>Aug 11 1917</i></p>		<p>5. TIME OF DEATH  <i>11:00 AM</i></p>		<p>6. PLACE OF DEATH  <i>Home</i></p>	
<p>7. CAUSE OF DEATH  <i>Heart Disease</i></p>		<p>8. DISEASE OR INJURY  <i>Myocardial Infarction</i></p>		<p>9. MANNER OF DEATH  <i>Natural</i></p>	
<p>10. SIGNATURE OF PHYSICIAN  <i>W. J. Williams</i></p>		<p>11. SIGNATURE OF WITNESS  <i>J. Williams</i></p>		<p>12. SIGNATURE OF DECEASED  <i>William J. Williams</i></p>	
<p>13. SIGNATURE OF REGISTRAR  <i>W. J. Williams</i></p>		<p>14. SIGNATURE OF CLERK  <i>W. J. Williams</i></p>		<p>15. SIGNATURE OF JURY  <i>W. J. Williams</i></p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
9121  
CERTIFICATE OF DEATH

09071

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Middletown</b>		c. LENGTH OF STAY IN 1b <b>years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Middletown</b>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Joseph</b> Last <b>Kefauver</b>		4. DATE OF DEATH Month <b>8</b> Day <b>27</b> Year <b>19 59</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/10/1882</b>
9. AGE (In years lost birthday) <b>77</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>farm owner, ret.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Lewis F. Kefauver</b>		14. MOTHER'S MAIDEN NAME <b>Joanna Cookerly</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs. William Kefauver, Middletown, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Generalized Arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 hrs</b> <b>14 yrs</b> <b>unknown</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10/5</b> , 19 <b>56</b> , to <b>8/27</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>8/27</b> , 19 <b>59</b> , and that death occurred at <b>11:29</b> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Kenneth C. Henson</b>		ADDRESS (Street, city or town, state) <b>2 Pinder Blvd., Middletown, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Kenneth Henson</b>		DATE SIGNED <b>8/29/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>8/30/1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Reformed Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Middletown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Gladhill Company, Middletown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 1 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			

CERTIFICATE OF DEATH

1911

1900

Blank certificate form with horizontal lines for text entry.

9092

## CERTIFICATE OF DEATH

Reg. Dist. No.

09072

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>				c. LENGTH OF STAY IN 1b <u>2 hrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hospital</u>				d. STREET ADDRESS <u>Sellman 15 X 2</u>			
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>EDGAR</u> Last <u>KNILL</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>5</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 2-1893</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>15</u>		11. IF UNDER 24 HRS. Hours <u>4</u> Min. <u>30</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Retired Farm owner</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>US</u>			
13. FATHER'S NAME <u>Simon P. Knill</u>				14. MOTHER'S MAIDEN NAME <u>Daley Slifer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>Informant</u>			
17. ADDRESS <u>Mrs. Edgar Knill, Sellman, Md.</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Posterior myocardial infarct</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u>Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Oberity</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Oberity</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>			
20c. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>			
20e. (City or town) <u>Frederick</u>				20f. (County) (State) <u>Maryland</u>			
21. I certify that I attended the deceased from <u>11 July, 1955</u> , to <u>5 Aug, 1959</u> , that I last saw the deceased alive on <u>5 Aug, 1955</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John G. Fawcett</u>				DATE SIGNED <u>5 Aug. 59</u>			
PHYSICIAN'S NAME (Type) <u>JOHN G. FAWCETT M.D.</u>				ADDRESS (Street, city or town, state) <u>P.O. Bayal, up</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Aug 8-59</u>				22b. DATE THEREOF <u>Aug 8-59</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>				22d. LOCATION (City, town, or county) (State) <u>Frederick Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Hillen, Barnesville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 10 '59</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9122

## CERTIFICATE OF DEATH

09073

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Emmitsburg,</b>				c. LENGTH OF STAY IN 1b <b>19 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>220 East Main</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Ella</b> Middle <b>Nora</b> Last <b>Knipple</b>				4. DATE OF DEATH Month <b>August</b> Day <b>19</b> Year <b>1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 6, 1880</b>	
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>19</b> Hours <b>59</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Frederick Co. Md.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Eli Knipple</b>				14. MOTHER'S MAIDEN NAME <b>Jennie Krug</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Harry K. Knipple</b>		Address <b>220 E. Main St. Emmitsburg, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>acute cardiac failure</b> <b>433.1</b> DUE TO (b) <b>arricular fibrillation</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>arteriosclerosis c.v. disease several years</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>6 mgs</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 18, 1959</b> to <b>Aug 19, 1959</b> , that I last saw the deceased alive on <b>Aug 18, 1959</b> , and that death occurred at <b>7 A. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Emmitsburg, Md.</b> DATE SIGNED <b>8-19-59</b>							
ACTUAL SIGNATURE <b>W. R. Cadle</b>				M.D. <b>Emmitsburg, Md.</b>			
PHYSICIAN'S NAME (Type) <b>W. R. Cadle</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 22, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt Tabor Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Rocky Ridge, Frederick Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. E. Wilson</b>				ADDRESS <b>Emmitsburg, Md.</b>		24a. REC'D BY REGISTRAR <b>Aug 20 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

1918

CERTIFICATE OF DEATH

9182

State of Maryland

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH		RACE		RELIGION		MARRIED		SINGLE		WIDOWED		DIVORCED		SEPARATED		MILITARY SERVICE		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		RACE OF DEATH		RELIGION OF DEATH		MARRIED OF DEATH		SINGLE OF DEATH		WIDOWED OF DEATH		DIVORCED OF DEATH		SEPARATED OF DEATH		MILITARY SERVICE OF DEATH	
JAMES H. HARRIS		Male		45		1873		Maryland		Baltimore		Maryland		White		Roman Catholic		Married		Yes		No		No		No		No		No		Baltimore		Maryland		White		Roman Catholic		Married		Yes		No		No		No					
Cause of Death		Immediate Cause		Intermediate Cause		Remote Cause		Contributing Cause		Manner of Death		Occupation		Education		Social Status		Economic Status		Mental Status		Physical Status		Moral Status		Religious Status		Political Status		Cultural Status		Artistic Status		Scientific Status		Literary Status		Musical Status		Dramatic Status		Circus Status		Circus Status		Circus Status		Circus Status					
Heart Disease		Coronary Artery Disease		Myocardial Infarction		Atherosclerosis		Hypertension		Natural		Physician		High School		Middle Class		Middle Class		Middle Class		Middle Class		Middle Class		Middle Class		Middle Class		Middle Class		Middle Class		Middle Class		Middle Class		Middle Class		Middle Class		Middle Class		Middle Class		Middle Class		Middle Class					
Date of Death		Place of Death		City of Death		Country of Death		Race of Death		Religion of Death		Married of Death		Single of Death		Widowed of Death		Divorced of Death		Separated of Death		Military Service of Death		Date of Death		Place of Death		City of Death		Country of Death		Race of Death		Religion of Death		Married of Death		Single of Death		Widowed of Death		Divorced of Death		Separated of Death		Military Service of Death							
1918		Baltimore		Maryland		White		Roman Catholic		Married		Yes		No		No		No		No		No		1918		Baltimore		Maryland		White		Roman Catholic		Married		Yes		No		No		No		No									

1918

1918

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
9112  
CERTIFICATE OF DEATH

09074

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brunswick</b>		c. LENGTH OF STAY IN 1b <b>35 Brunswick</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>109 East "A"</b>		d. STREET ADDRESS <b>109 East "A"</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Edward</b> Middle <b>Adam</b> Last <b>Koegel</b>		4. DATE OF DEATH Month <b>8</b> Day <b>7</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-27-1890</b>
9. AGE (In years last birthday) <b>69</b> yrs.		10. IF UNDER 1 YEAR Months <b>8</b> Days <b>7</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Matinance Dep.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Western Md. R.R.</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Hiram Koegel</b>		14. MOTHER'S MAIDEN NAME <b>Sophia Ruchlein</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>705-10-6094</b>	
17. INFORMANT <b>Mrs. Maude Koegel, Brunswick, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 12</b> , 19 <b>59</b> , to <b>Aug. 7</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Aug. 7</b> , 19 <b>59</b> , and that death occurred at <b>10:20 p.m.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>15 S. Maryland Ave. Aug. 8, 59</b> ACTUAL SIGNATURE <b>C. T. Byron Kao, M.D.</b> M.D. <b>Brunswick, Md.</b> PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-10-1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Park Heights</b>		22d. LOCATION (City, town, or county) (State) <b>Brunswick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. Lee Fuchs</b> ADDRESS <b>Brunswick, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 11 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Charles S. Kraus</b>			

1942

CERTIFICATE OF DEATH

1942

1. Name of deceased: \_\_\_\_\_

2. Sex: \_\_\_\_\_

3. Age: \_\_\_\_\_

4. Date of birth: \_\_\_\_\_

5. Place of birth: \_\_\_\_\_

6. Date of death: \_\_\_\_\_

7. Place of death: \_\_\_\_\_

8. Cause of death: \_\_\_\_\_

9. Signature of physician: \_\_\_\_\_

10. Signature of registrar: \_\_\_\_\_

11. Date of registration: \_\_\_\_\_

12. Place of registration: \_\_\_\_\_

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**9123**  
**CERTIFICATE OF DEATH**

09075

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cullen</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seat Pleasant</u> 16X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Victor Cullen State Hospital</u>		d. STREET ADDRESS <u>316 Carmody Hills Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>Hester</u> Middle <u>V.</u> Last <u>Kravitsky</u>		4. DATE OF DEATH Month <u>8</u> Day <u>20</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-4-1907</u>
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alexander Windsor</u>		14. MOTHER'S MARRIED NAME <u>Mary Emily</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Hospital record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Tuberculosis - 002</u> <u>002X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cirrhosis of liver - 581, Neuro-syphilis - 026</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7/22</u> , 19 <u>59</u> , to <u>8/20</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>8/19</u> , 19 <u>59</u> , and that death occurred at <u>3:05 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>T.F. Vestal</u>		ADDRESS (Street, city or town, state) <u>Cullen, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>Thomas F. Vestal M.D.</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8-24-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>M. L. Swager + Son Thruout Md.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 21 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Cullen &amp; Hester</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9093

## CERTIFICATE OF DEATH

Reg. Dist. No.

09076

1. PLACE OF DEATH a. COUNTY <b>FREDERICK</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FREDERICK</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>F.M.H.</b>		d. STREET ADDRESS <b>525 Mary Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Baby</b> Middle <b>Boy</b> Last <b>Kuehne</b>		4. DATE OF DEATH Month <b>8</b> Day <b>13</b> Year <b>1959</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-13-59</b>
9. AGE (In years last birthday) <b>0</b> yrs.		IF UNDER 1 YEAR Months <b>4</b> Days <b>1</b> Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Frederick, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Ralph W. Kuehne</b>		14. MOTHER'S MAIDEN NAME <b>Merle Ann Emmons</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Ralph W. Kuehne (Same as item #2)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>762.5</b> <b>fatal atelectasis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Immaturity</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8-13</b> , 19 <b>59</b> , to <b>8-13</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>8-13</b> , 19 <b>59</b> , and that death occurred at <b>9 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>14 Aug 1959</b>			
ACTUAL SIGNATURE <b>Fred W. Hezdrich Jr M.D.</b>			
PHYSICIAN'S NAME (Type) <b>FRED W. HEZDRICH JR M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-15-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		24a. REC'D BY REGISTRAR <b>AUG 17 59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>			

2069264XVI



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9124

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G246 8-13-59 et

CERTIFICATE OF DEATH

09077

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Baltimore</b> , 24 b. COUNTY <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cullen</b>		c. LENGTH OF STAY IN TB <b>107 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Victor Cullen State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Howard E. KUHN</b>		4. DATE OF DEATH <b>August 9 19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-16-1909</b> 49 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Manager</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Junk Yard</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry A. Kuhn</b>		14. MOTHER'S MAIDEN NAME <b>Frances Schroeder</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213 01 0470</b>	
17. INFORMANT <b>Patient</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Far Advanced Bilateral Pulmonary Tuberculosis 1 Yr.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 24 1959</b> , to <b>Aug. 9 1959</b> , that I last saw the deceased alive on <b>Aug. 8 1959</b> , and that death occurred at <b>4:15 A.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>T. F. Vestal</b>		ADDRESS (Street, city or town, state) <b>Cullen, Md.</b> DATE SIGNED <b>Aug 9, 1959</b>	
PHYSICIAN'S NAME (Type) <b>T. F. Vestal, M. D.</b>		<b>Cullen, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-12-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Schwartz Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. A. Calney</b>		ADDRESS <b>3000 E. North St. Baltimore, Md.</b>	
24a. REC'D BY REGISTRAR <b>DATE AUG 11 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

SEX

RACE



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
9094  
CERTIFICATE OF DEATH

09078

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick, Md.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>				c. LENGTH OF STAY IN 1b <u>7 yr.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Wilma</u> Middle <u>IRENE</u> Last <u>Lenhart</u>				4. DATE OF DEATH Month <u>August</u> Day <u>7</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>18 April 1882</u>	9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>7</u> Hours <u>1</u> Min. <u>52</u>	IF UNDER 24 HRS. Months <u>7</u> Days <u>7</u> Hours <u>1</u> Min. <u>52</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>Thomas A. Lenhart</u>			
14. MOTHER'S MAIDEN NAME <u>Louise D. Rice</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>Thomas Lenhart</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brain tumor</u> 237X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				INTERVAL BETWEEN ONSET AND DEATH <u>1 p.m.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>4 Aug.</u> , 19 <u>58</u> , to <u>7 Aug.</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6 Aug.</u> , 19 <u>59</u> , and that death occurred at <u>5:30</u> AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Al. Powell</u>				DATE SIGNED <u>7 Aug. 59</u>			
PHYSICIAN'S NAME (Type) <u>Albert M. Powell, M.D.</u>				ADDRESS (Street, city or town, state) <u>Medicine Lane, Fred. Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 10, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>M. R. Etchison &amp; Son, Frederick, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 10 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

CERTIFICATE OF DEATH

2008

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		65		M		W		1843		BALTIMORE, MD.	
MARRIED		WIFE		NAME		AGE		DATE OF DEATH		PLACE OF DEATH	
MARRIED		WIFE		MARY H. HARRIS		62		1908		BALTIMORE, MD.	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		SPECIAL INSTRUCTIONS	
HEART DISEASE		NATURAL		LABORER		HIGH SCHOOL		METHODIST		NONE	
DATE OF DEATH		PLACE OF DEATH		NAME OF PHYSICIAN		NAME OF HOSPITAL		NAME OF BURIAL PLACE		NAME OF FUNERAL HOME	
1908		BALTIMORE, MD.		J. H. HARRIS		BALTIMORE HOSPITAL		GREENWOOD CEMETERY		HARRIS & SONS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF FUNERAL HOME		SIGNATURE OF BURIAL PLACE		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN	
J. H. HARRIS		HARRIS & SONS		GREENWOOD CEMETERY		J. H. HARRIS, MARY H. HARRIS		JAMES H. HARRIS		MARY H. HARRIS	

1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
SM 9/55

9125

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09079

1. PLACE OF DEATH a. COUNTY <u>Fredrick</u> <u>Emmitsburg</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Fred.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Emmitsburg</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Floyd Calvin Manning</u>		4. DATE OF DEATH Month <u>August</u> Day <u>18</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 31, 1953</u>
9. AGE (In years last birthday) <u>6</u> yrs.		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>18</u> Hours <u>18</u> Min. <u>59</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Gettysburg, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Floyd Calvin Manning Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Welch</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Calvin Manning</u>		Address <u>Emmitsburg Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sun Shot wound in Skull</u> <u>919.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>&amp; Brain</u> DUE TO (c) <u>minutes</u>		INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot by older brother (9 years old)</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>11:05</u> a.m. <u>8/18</u> 19 <u>59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Emmitsburg Fredrick Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>B. O. Thomas</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>B. O. Thomas, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>August 18, 1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 20, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Highfield, Washington Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. E. Wilson</u>		ADDRESS <u>Emmitsburg, Md.</u>	
24a. REC'D BY REGISTRAR <u>Aug 20 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

C. E. Wilson



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

09080

9126

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Frederick</b>				c. LENGTH OF STAY IN 1b <b>5 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Route 3</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Georgia</b> Middle <b>A.</b> Last <b>McQueen</b>				4. DATE OF DEATH Month <b>August</b> Day <b>9th</b> Year <b>19 59</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. <del>MARRIED</del> <del>WIDOWED</del> <del>NEVER MARRIED</del> <del>SEPARATED</del> <b>WIDOWED</b>		8. DATE OF BIRTH <b>Feb. 22-1875</b>	
9. AGE (In years last birthday) <b>84</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>West Virginia</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>	
13. FATHER'S NAME <b>Freeman Doak</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Burnside</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Gertrude Wilson-Rt.3- Frederick-Md.(sister)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broucho pneumonia</b> <b>332x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral artery thrombosis</b> DUE TO (c) <b>General atherosclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>7 years</b> <b>Rubman</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>6/14</b> , 19 <b>59</b> , to <b>8/9</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>8/9</b> , 19 <b>59</b> , and that death occurred at <b>2:30 p.m.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Professional Bldg.</b> DATE SIGNED <b>8/11/59</b> ACTUAL SIGNATURE <b>L.R. Schoolman</b> M.D. PHYSICIAN'S NAME (Type) <b>Dr. L.R. Schoolman</b> <b>Frederick- Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-12-1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick - Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Dailor's Funeral Home</b> ADDRESS <b>Frederick- Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>AUG 17 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Haines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9095

## CERTIFICATE OF DEATH

Reg. Dist. No.

09081

1. PLACE OF DEATH a. COUNTY <u>FREDERICK</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR RURAL</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FREDERICK MEMORIAL HOSPITAL</u>		d. STREET ADDRESS <u>MARSTON 06X-2</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Ada</u> First <u>MAE</u> Middle <u>Miller</u> Last		4. DATE OF DEATH <u>Aug.</u> Month <u>4</u> Day <u>1959</u> Year	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 8-1892</u> 9. AGE (In years last birthday) <u>66</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE KEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>SAMUEL W. GLOVER</u>		14. MOTHER'S MAIDEN NAME <u>HARRIETT DEEDS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217-12-7155</u>	
17. INFORMANT <u>W. EXRAMILLER, NEW WINDSOR MD</u>		Address <u>RURAL</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 WKS</u> <u>4-5 yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 22</u> , 19 <u>58</u> , to <u>Aug 4</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Aug 4</u> , 19 <u>59</u> , and that death occurred at <u>10:50 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Henry V. Chase</u> M.D.		ADDRESS (Street, city or town, state) <u>4 E. Church St</u> DATE SIGNED <u>8/4/59</u>	
PHYSICIAN'S NAME (Type) <u>Henry V. Chase</u>		<u>Frederick Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>AUG 9-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>DEER PARK CEM</u>		22d. LOCATION (City, town, or county) (State) <u>SMALLWOOD MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>D. H. Hartsler, 1405 New Windsor, Md</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>AUG 7 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Hume</u>	

10003

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

CERTIFICATE OF DEATH

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<p>1. NAME OF DECEASED <i>John Doe</i></p>		<p>2. SEX <i>Male</i></p>		<p>3. AGE <i>45</i></p>	
<p>4. DATE OF DEATH <i>Jan 15 1950</i></p>		<p>5. TIME OF DEATH <i>10:00 AM</i></p>		<p>6. PLACE OF DEATH <i>Home</i></p>	
<p>7. CAUSE OF DEATH <i>Myocardial Infarction</i></p>		<p>8. MANNER OF DEATH <i>Natural</i></p>		<p>9. PLACE OF BIRTH <i>Baltimore, Md.</i></p>	
<p>10. OCCUPATION <i>Teacher</i></p>		<p>11. MARITAL STATUS <i>Married</i></p>		<p>12. EDUCATION <i>High School</i></p>	
<p>13. PREVIOUS ILLNESS <i>None</i></p>		<p>14. MEDICAL HISTORY <i>None</i></p>		<p>15. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>16. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>17. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>18. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>19. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>20. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>21. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>22. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>23. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>24. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>25. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>26. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>27. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>28. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>29. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>30. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>31. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>32. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>33. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>34. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>35. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>36. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>37. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>38. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>39. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>40. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>41. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>42. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>43. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>44. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>45. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>46. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>47. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>48. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>49. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>50. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>51. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>52. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>53. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>54. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>55. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>56. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>57. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>58. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>59. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>60. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>61. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>62. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>63. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>64. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>65. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>66. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>67. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>68. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>69. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>70. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>71. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>72. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>73. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>74. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>75. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>76. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>77. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>78. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>79. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>80. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>81. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>82. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>83. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>84. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>85. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>86. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>87. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>88. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>89. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>90. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>91. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>92. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>93. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>94. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>95. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>96. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>97. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>98. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>99. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>100. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>101. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>102. SIGNATURE OF WITNESS <i>John Doe</i></p>	

10003

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**9113**  
**CERTIFICATE OF DEATH**

09082

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Frederick</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brunswick</b>				c. LENGTH OF STAY IN 1b <b>years 35</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Emma</b> Middle <b>V.</b> Last <b>Moler</b>				4. DATE OF DEATH Month <b>8</b> Day <b>12</b> Year <b>19 59</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/13/1873</b>	9. AGE (In years lost birthday) <b>86 yrs.</b>	IF UNDER 1 YEAR Months <b>86</b> Days <b>86</b> Hours <b>86</b> Min. <b>86</b>	IF UNDER 24 HRS. Months <b>86</b> Days <b>86</b> Hours <b>86</b> Min. <b>86</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>James Gordon</b>			14. MOTHER'S MAIDEN NAME <b>Nancy 7</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mrs. Earl Gordon, Brunswick, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.0</b> DUE TO <b>arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>June 1945</b> to <b>Aug 12 1959</b> , that I last saw the deceased alive on <b>Aug 8 1959</b> , and that death occurred at <b>12 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Dr. J. G. F. Smith</b>				ADDRESS (Street, city or town, state) <b>Brunswick Md.</b>			
PHYSICIAN'S NAME (Type) <b>Dr. J. G. F. Smith</b>				DATE SIGNED <b>8/12/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>8/14/1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Pleasant View Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Middletown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>gladhill Company, Middletown, Md.</b>				24a. REC'D BY REGISTRAR <b>AUG 17 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Robert S. Smith</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2113

NAME OF DECEASED <i>John William Smith</i>		AGE <i>45</i>		SEX <i>Male</i>		RACE <i>White</i>		DATE OF BIRTH <i>Jan 15 1878</i>		PLACE OF BIRTH <i>St. Louis, Mo.</i>		CITY OF RESIDENCE <i>Baltimore, Md.</i>		COUNTY OF RESIDENCE <i>Baltimore</i>		STATE OF RESIDENCE <i>Md.</i>		CITY OF DEATH <i>Baltimore</i>		COUNTY OF DEATH <i>Baltimore</i>		STATE OF DEATH <i>Md.</i>			
DATE OF DEATH <i>Dec 10 1913</i>		TIME OF DEATH <i>10:30 AM</i>		PLACE OF DEATH <i>Home</i>		CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>		DISEASE OR INJURY <i>Coronary Artery Disease</i>		SYMPTOMS <i>None</i>		PREVIOUS ILLNESS <i>None</i>		PREVIOUS SURGERY <i>None</i>		PREVIOUS TRAUMA <i>None</i>		PREVIOUS TOXICITY <i>None</i>		PREVIOUS INFECTION <i>None</i>		PREVIOUS OTHER <i>None</i>	
SIGNATURE OF DECEASED <i>John William Smith</i>		SIGNATURE OF NEXT OF KIN <i>John William Smith</i>		SIGNATURE OF PHYSICIAN <i>John William Smith</i>		SIGNATURE OF CLERK <i>John William Smith</i>		SIGNATURE OF JURY <i>John William Smith</i>		SIGNATURE OF JUDGE <i>John William Smith</i>		SIGNATURE OF SHERIFF <i>John William Smith</i>		SIGNATURE OF CORONER <i>John William Smith</i>		SIGNATURE OF DISTRICT ATTORNEY <i>John William Smith</i>		SIGNATURE OF COUNTY CLERK <i>John William Smith</i>		SIGNATURE OF CITY CLERK <i>John William Smith</i>		SIGNATURE OF STATE CLERK <i>John William Smith</i>		SIGNATURE OF NATIONAL CLERK <i>John William Smith</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9096

## CERTIFICATE OF DEATH

09083

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN TB <b>50 Years</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		d. STREET ADDRESS <b>201 Linden Avenue</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>201 Linden Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ALICE</b> Middle <b>VIRGINIA</b> Last <b>MULL</b>		4. DATE OF DEATH Month <b>August</b> Day <b>8</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10 Nov 1875</b>
9. AGE (In years last birthday) yrs. <b>83</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George H. Mull</b>		14. MOTHER'S MAIDEN NAME <b>Martha Getzandanner</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. James Albright, Sr. (Same as item #1)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June</b> , 19 <b>50</b> , to <b>Aug 8</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Aug 7</b> , 19 <b>59</b> , and that death occurred at <b>2 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>228 N. Market St. 9 Aug 1959</b> ACTUAL SIGNATURE <b>B. O. Thomas</b> M.D. PHYSICIAN'S NAME (Type) <b>B. O. Thomas, M. D.</b> Frederick, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-11-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		ADDRESS <b>Frederick, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>AUG 11 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. King</b>	





## CERTIFICATE OF DEATH

Reg. Dist. No.

9127

1. PLACE OF DEATH a. COUNTY <b>FREDERICK</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>FREDERICK</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>NEW WINDSOR</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>NEW WINDSOR</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>RURAL</b>				d. STREET ADDRESS <b>RURAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>WILLIAM JENNINGS NULL</b>				4. DATE OF DEATH <b>AUG. 20 19 59</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JUNE 18 - 1896</b>	
9. AGE (In years last birthday) <b>63</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>JOHN NULL</b>				14. MOTHER'S MAIDEN NAME <b>MARTHA CHEEKS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT Address <b>MAMIE H. NULL, NEW WINDSOR MD</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> <b>Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>angina pectoris</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b> <b>6 yrs.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8/20/59</b> to <b>8/20/59</b> , that I last saw the deceased alive on <b>8/20/59</b> , and that death occurred at <b>2:30 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>M. E. Robertson</b>				ADDRESS (Street, city or town, state) <b>New Windsor, Md.</b>		DATE SIGNED <b>8/20/59</b>	
PHYSICIAN'S NAME (Type) <b>M. E. ROBERTSON</b>				NEW WINDSOR MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>8/22/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>CHURCH OF GOD CEM. UNIONTOWN</b>		22d. LOCATION (City, town, or county) (State) <b>MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>D. D. Hartley</b>				ADDRESS <b>New Windsor Md</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 24 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 10

1985

1. NAME OF DECEASED: JOHN W. WILSON

2. SEX: Male

3. AGE: 68

4. DATE OF BIRTH: 11/15/1917

5. PLACE OF BIRTH: NEW YORK, N.Y.

6. RACE: White

7. OCCUPATION: Retired

8. MARITAL STATUS: Married

9. DATE OF DEATH: 11/15/1985

10. TIME OF DEATH: 10:15 AM

11. PLACE OF DEATH: Home

12. CAUSE OF DEATH: Heart Disease

13. MANNER OF DEATH: Natural

14. SIGNATURE OF PHYSICIAN: [Signature]

15. SIGNATURE OF REGISTRAR: [Signature]

16. COUNTY: Harford

17. CITY: Bel Air

18. ZIP CODE: 21034

19. COUNTY CLERK: [Signature]

20. REGISTRAR: [Signature]



THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MD, AND IN THE OFFICE OF THE COUNTY CLERK, HARFORD COUNTY, MD.

ATTEST: [Signature]

CLERK OF THE BOARD OF HEALTH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

M

069

12

2

VS. A15ME  
SM 2/57

9097

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09085

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN lb <b>50 Yrs.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick-Rural RD#7</b>		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Frederick Memorial Hospital</b>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		d. STREET ADDRESS <b>Near Frederick</b>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>WILLIAM</b> Last <b>O'NEAL</b>		4. DATE OF DEATH Month <b>August</b> Day <b>14</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>26 Oct 1899</b>
9. AGE (In years last birthday) <b>59</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook &amp; Gardner</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George W. O'Neal</b>		14. MOTHER'S MAIDEN NAME <b>Julia Putman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-10-9654</b>	
17. INFORMANT <b>Mrs. George F. Hutto, 914 Pine Ave., Frederick, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) [a], stating the underlying cause last. (c)	
INTERVAL BETWEEN ONSET AND DEATH <b>2 Hours</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>420.1</b>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a. m. p. m.	
20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <b>B. O. Thomas</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>B. O. Thomas, M. D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>14 Aug 1959</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-17-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Lutheran Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Middletown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Md.</b>		ADDRESS <b>Frederick, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>AUG 17 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hutto</b>	





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 2/57

9128

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09086

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) ✓ a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Park Mills Md</b>		c. LENGTH OF STAY IN 1b <b>1 week</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brentwood, Md.</b> 16X-2			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Adamstown Route 1</b>				d. STREET ADDRESS <b>3712 Taylor St</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Harriett Norris Poole</b>				4. DATE OF DEATH Month <b>August</b> Day <b>27</b> , Year <b>19 59-</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct 27, 1881</b>		9. AGE (In years last birthday) <b>77</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>Washington D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>William Woodbury</b>				14. MOTHER'S MAIDEN NAME <b>Mary Chase</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Edgar Morris Poole Brentwood, Maryland.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>B. O. Thomas</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>B. O. Thomas, M. D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/31/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons Hyattsville, Md.</b>				24a. REC'D BY REGISTRAR <b>SEP 1 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9129

CERTIFICATE OF DEATH

09087

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cullen</u>				c. LENGTH OF STAY IN 1b <u>16 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Victor Cullen State Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>William Emory REDDING</u>				4. DATE OF DEATH Month <u>August</u> Day <u>14</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 24, 1867</u>	9. AGE (In years last birthday) <u>91</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Shipping</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>William Redding</u>				14. MOTHER'S MAIDEN NAME <u>Elma Eliza beth Bumber</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>216-16-1793</u>		17. INFORMANT <u>Grand Daughter</u> Address _____			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Far Advanced Pulmonary Tuberculosis</u> <u>002X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>1 Yr.??</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis General</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>7/29</u> , 19 <u>59</u> , to <u>8/14</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>8/14/59</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>T. F. Vestal</u>		ADDRESS (Street, city or town, state) <u>Cullen, Md.</u>				DATE SIGNED <u>8/14/1959</u>	
PHYSICIAN'S NAME (Type) <u>T. F. Vestal, M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-17-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>M. L. Greager &amp; Son</u>				ADDRESS <u>Thurmont Md</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 19 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Carlton S. Kraus</u>			

CERTIFICATE OF DEATH

1158

EXHIBIT BOND

Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to the quality of the scan.



Handwritten signature or initials at the bottom of the page.

1  
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 9130  
 CERTIFICATE OF DEATH

09088

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Point of Rocks</b>		c. LENGTH OF STAY IN 1b <b>50 Years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>RAYHU</b> Last <b>REDMOND</b>		4. DATE OF DEATH Month <b>August</b> Day <b>16</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 11, 1884</b>
9. AGE (In years last birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Watchman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Lime Company</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph C. Redmond</b>		14. MOTHER'S MAIDEN NAME <b>Oleva A. Pryor</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-07-2319</b>	
17. INFORMANT <b>Mr. Verner A. Redmond-Same as Item #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO <b>Chronic Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>years</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1-1-1959</b> to <b>8-16-1959</b> , that I last saw the deceased alive on <b>8-15-1959</b> , and that death occurred at <b>9:30 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>[Signature]</b>		ADDRESS (Street, city or town, state) <b>45 Petersville Road</b> DATE SIGNED <b>8/18/59</b>	
PHYSICIAN'S NAME (Type) <b>C. E. Pruitt, M. D.</b>		Brunswick, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Aug. 20, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Paul's Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Point of Rocks, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>AUG 20 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	



# CERTIFICATE OF DEATH

1150

Registration

Signature

Date

Address

Place of Birth

Age

Place of Death

Sex

Color

Height

Weight

Build

Time of Death

Day

Month

Year

Signature

Signature

Signature

1

*Handwritten signature and text*

Witness

Signature

Signature

Signature

Signature

9098

CERTIFICATE OF DEATH

Reg. Dist. No.

09089

1. PLACE OF DEATH a. COUNTY <b>FREDERICK</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>FREDERICK</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FREDERICK</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>THURMONT</b>	
c. LENGTH OF STAY IN TB <b>4 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>FREDERICK MEMORIAL HOSP</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MAURICE</b> Middle <b>ORVILLE</b> Last <b>REED</b>		4. DATE OF DEATH Month <b>8</b> Day <b>5</b> Year <b>1959</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/30/02</b>
9. AGE (In years last birthday) <b>56 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sanitary</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Cannon Shop</b>	
11. BIRTHPLACE (State or foreign country) <b>Ind</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>W. Reed</b>		14. MOTHER'S MAIDEN NAME <b>Mary E. Stately</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>218-09-0056</b>	
17. INFORMANT <b>Lillian F. Reed</b>		Address <b>Thurmont Rd 1</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary infarct</b> DUE TO <b>430.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Artery Disease and</b> (c) <b>Congestive Heart Failure</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>6 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>8/5/59</b> Hour <b>8</b> m. <b>30</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8/2</b> , 19 <b>57</b> , to <b>8/5</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>8/5</b> , 19 <b>57</b> , and that death occurred at <b>9:30 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Richard C. Reynolds</b> M.D.		ADDRESS (Street, city or town, state) <b>9 East Church St.</b> DATE SIGNED <b>8/5/59</b>	
PHYSICIAN'S NAME (Type) <b>Richard C. Reynolds</b>		<b>Fredricks, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Aug 8-1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Blue Ridge Cem</b>	22d. LOCATION (City, town, or county) (State) <b>Thurmont Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond G. Treager</b>		ADDRESS <b>Thurmont</b>	
24a. REC'D BY REGISTRAR <b>AUG 10 59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

1  
9099  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
CERTIFICATE OF DEATH

09090

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>7 Hours</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>VADA</b> Middle <b>FRANCES</b> Last <b>REEDER</b>		4. DATE OF DEATH Month <b>August</b> Day <b>30</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 27, 1892</b>
9. AGE (In years last birthday) <b>67</b>		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George C. Shafer</b>		14. MOTHER'S MAIDEN NAME <b>Laura V. Thomas</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Mr. Joseph L. Reeder-Same as Item #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertension</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b> <b>3 yrs +</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April</b> , 19 <b>35</b> , to <b>Aug 30</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Aug. 29</b> , 19 <b>59</b> , and that death occurred at <b>9:15A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Professional Building</b> DATE SIGNED <b>8/31/59</b> ACTUAL SIGNATURE <b>B. O. Thomas</b> M.D. PHYSICIAN'S NAME (Type) <b>B. O. Thomas, M. D.</b> <b>Frederick, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 1, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 2 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>			

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WASHINGTON, D. C. MAY 19 1964

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CERTIFICATE OF ADOPTION

Produced by

THE NATIONAL ARCHIVES

1964

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VS A15 (4)  
15M 10/57

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9131

## CERTIFICATE OF DEATH

09091

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Virginia</b> b. COUNTY <b>Loudoun Co. Va.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Braddock Heights</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lovettsville, Va. 83x3</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Vindobona Convalescent &amp; Rest Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LESTER</b> Middle <b>SCHUTTE</b> Last <b>SCHUTTE</b>		4. DATE OF DEATH Month <b>August</b> Day <b>12</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 23, 1881</b>
9. AGE (In years last birthday) <b>77</b> yrs.		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>22</b>	11. IF UNDER 24 HRS. Hours <b>11</b> Min. <b>22</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Investor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Investments</b>	
11. BIRTHPLACE (State or foreign country) <b>Brooklyn, N.Y.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Schutte</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Lorena W. Schutte (Wife)</b>		Address <b>Lovettsville, Va.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Squamous cell epithelioma of mouth</b> <b>1919</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7/9</b> , 19 <b>59</b> , to <b>8/12</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>8/11</b> , 19 <b>59</b> , and that death occurred at <b>2:15 A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>L. R. Schoolman</b>		DATE SIGNED <b>12 Aug 1959</b>	
PHYSICIAN'S NAME (Type) <b>L. R. Schoolman, M. D.</b>		ADDRESS (Street, city or town, state) <b>228 N. Market St., Frederick, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 14, 59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Union Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Lovettsville Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 14 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>			

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

9100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09092

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>FREDERICK</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FREDERICK</b> c. LENGTH OF STAY IN 1b <b>Lifetime</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>FREDERICK MEMORIAL HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>FREDERICK</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick, Maryland</b> d. STREET ADDRESS <b>Frederick, Md.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ALMA</b> Middle <b>LARE</b> Last <b>SCOTT</b>		4. DATE OF DEATH Month <b>August</b> Day <b>14</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 27, 1898</b>
9. AGE (In years last birthday) <b>61</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seamstress</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Seamstress</b>	
11. BIRTHPLACE (State or foreign country) <b>Frederick, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME <b>George V. McC. Lare</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Ellen Hamilton</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Sister Mrs. Charles Riddlemoser,</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gun Shot wound of Skull</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>981x</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shot thru skull</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>7</b> p. m. <b>8, 14 1959</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Shooktown Road Home</b>		20f. (City or town) <b>Frederick</b> (County) <b>Frederick</b> (State) <b>Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>B.O. Thomas</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>B.O. THOMAS, MD.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL, or disposal <b>ENTOMBMENT</b>		22b. DATE THEREOF <b>Aug. 17, 59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Fred. Memorial Park,</b>		22d. LOCATION (City, town, or county) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Philo B. Gales</b>		24a. REC'D BY REGISTRAR <b>AUG 18 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Froust</b>	

MEDICAL CERTIFICATE

DEATH - MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DEATH OF NAME IN DEATH		DEATH OF NAME IN DEATH	
SEX MALE FEMALE		SEX MALE FEMALE	
AGE YEARS MONTHS DAYS		AGE YEARS MONTHS DAYS	
DATE OF DEATH MONTH DAY YEAR		DATE OF DEATH MONTH DAY YEAR	
PLACE OF DEATH CITY COUNTY STATE		PLACE OF DEATH CITY COUNTY STATE	
OCCUPATION TRADE VOCATION		OCCUPATION TRADE VOCATION	
CAUSE OF DEATH DISEASE INJURY		CAUSE OF DEATH DISEASE INJURY	
MANNER OF DEATH NATURAL ACCIDENT SUICIDE HOMICIDE		MANNER OF DEATH NATURAL ACCIDENT SUICIDE HOMICIDE	
SIGNATURE OF EXAMINER NAME TITLE		SIGNATURE OF EXAMINER NAME TITLE	
SIGNATURE OF WITNESS NAME TITLE		SIGNATURE OF WITNESS NAME TITLE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

9101

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09093

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rosemont Ave. Frederick, Md.</b>				d. STREET ADDRESS <b>1631 Shookstown Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Henry</b> Last <b>Scott</b>				4. DATE OF DEATH Month <b>August</b> Day <b>14</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>February 28, 1888</b>	
9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months <b>14</b> Days <b>14</b> Hours <b>19</b> Min.		IF UNDER 24 HRS. Hours <b>19</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired carpenter</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Missouri</b>	
13. FATHER'S NAME <b>Joseph Arnote</b>				14. MOTHER'S MAIDEN NAME <b>Katheryn Neill</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>529-01-1323</b>		17. INFORMANT <b>(Daughter) Ilene Tillson, Princeton, Missouri</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gun shot wound of skull</b> 976x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 hours</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Gun shot wound of skull, Self inflicted</b>					
20c. TIME OF INJURY Month, Day, Year Hour <b>7:30</b> o. m. <b>8/17</b> p. m. <b>1959</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Rosemont Ave</b>		20f. (City or town) (County) (State) <b>Frederick Frederick Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>B. O. Thomas</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Dr. B. O. Thomas, Sr.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>8/16/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Princeton, Missouri</b>		22d. LOCATION (City, town, or county) (State) <b>Princeton, Missouri</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert E. Bailey</b>				ADDRESS <b>Frederick, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 18 '59</b>	
						24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

DATE SIGNED  
**August 16, 1959**



STATE OF CALIFORNIA  
DEPARTMENT OF HEALTH - BATHING  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
John Doe		Male		45		10-15-1923	
Residence		Occupation		Cause of Death		Manner of Death	
123 Main St., Los Angeles, Cal.		Teacher		Heart Disease		Natural	
Physician		Hospital		Burial		Interment	
Dr. J. Smith		St. Mary's Hospital		Crematorium		Cemetery	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Clerk	
J. A. Doe		W. B. Smith		C. D. Jones		E. F. Brown	
Date of Examination		Time of Examination		Place of Examination		Signature of Deceased	
10-15-1923		10:00 AM		St. Mary's Hospital		John Doe	
Witness		Witness		Witness		Witness	
A. B. C.		D. E. F.		G. H. I.		J. K. L.	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Clerk	
J. A. Doe		W. B. Smith		C. D. Jones		E. F. Brown	
Date of Examination		Time of Examination		Place of Examination		Signature of Deceased	
10-15-1923		10:00 AM		St. Mary's Hospital		John Doe	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9102

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 6 Film G246 8-12-59 et

## CERTIFICATE OF DEATH

09094

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>Years(19)</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>		d. STREET ADDRESS <b>413 East Patrick Street</b>	
3. NAME OF DECEASED (Type or print) First <b>ALBERT</b> Middle <b>LEWIS</b> Last <b>SEEGER</b>		4. DATE OF DEATH Month <b>August</b> Day <b>4,</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 26, 1864</b>
9. AGE (In years last birthday) yrs. <b>95</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railway Express</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Peter Seeger</b>		14. MOTHER'S MAIDEN NAME <b>Maria Woerner</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Miss Katherine Seeger-Same as Item #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Rectum</b> <b>154X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>18 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 1, 1958</b> , to <b>Aug 4, 1959</b> , that I last saw the deceased alive on <b>Aug 4, 1959</b> , and that death occurred at <b>12:20 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>West Third Street</b> <b>8/6/59</b>			
ACTUAL SIGNATURE <b>Thomas E. Stone</b>		M.D. <b>Frederick, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Thomas E. Stone, MB.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 6, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		ADDRESS <b>Frederick, Maryland</b>	
24a. REC'D BY REGISTRAR <b>AUG 7 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

CERTIFICATE OF DEATH

108

Name of Deceased [Name]		Sex [Sex]	
Date of Birth [Date]		Age [Age]	
Place of Birth [Place]		Usual Residence [Address]	
Cause of Death [Cause]		Date of Death [Date]	
Physician [Physician]		Coroner [Coroner]	
Burial Place [Burial Place]		Date of Burial [Date]	
Signature of Physician [Signature]		Signature of Coroner [Signature]	
Signature of Registrar [Signature]		Signature of Clerk [Signature]	

9103

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09095

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>Years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>205 West Second Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>DORSEY</b> Middle <b>FRANKLIN</b> Last <b>SHIPLEY</b>		4. DATE OF DEATH Month <b>August</b> Day <b>24,</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 20, 1907</b>
9. AGE (In years last birthday) yrs. <b>52</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Merchant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Sporting Goods</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Harry F. Shipley</b>		14. MOTHER'S MAIDEN NAME <b>Fanny Easterday</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>WW2 214-10-1891</b>	
17. INFORMANT <b>Mrs. Virginia C. Shipley</b>		Address <b>-Same as Item #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>181.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>Carcinoma of the bladder</b> DUE TO (c) <b>Extensive metastases</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>29 May, 1958</b> to <b>24 May, 1959</b> , that I last saw the deceased alive on <b>24 May, 1959</b> , and that death occurred at <b>5:00 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Robert D. Crouch</b>		ADDRESS (Street, city or town, state) <b>Shopping Center</b>	
PHYSICIAN'S NAME (Type) <b>Robert D. Crouch, M.D.</b>		DATE SIGNED <b>8/26/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 27, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>
22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		ADDRESS <b>Frederick, Maryland</b>	
24a. REC'D BY REGISTRAR DATE <b>AUG 28 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

2000

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 10/57

9132

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

09096

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegheny</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cullen</u>		c. LENGTH OF STAY in 1b <u>84 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Victor Cullen State Hospital</u>		d. STREET ADDRESS <u>42 N. Water St</u>	
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>C.</u> Last <u>Shuckhart</u>		4. DATE OF DEATH Month <u>8</u> Day <u>5</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 8, 1876</u>
9. AGE (In years lost birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tailor</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Conrad Shuckhart</u>		14. MOTHER'S MAIDEN NAME <u>Mary Geis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Victor Cullen Hospital Record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Tuberculosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/13</u> , 19 <u>59</u> , to <u>8/5</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>8/4</u> , 19 <u>59</u> , and that death occurred at <u>11:40 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>T.F. [Signature]</u>		ADDRESS (Street, city or town, state) <u>Victor Cullen State Hospital</u>	
PHYSICIAN'S NAME (Type) <u>Cullen, Md.</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-8-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Frostburg Mem. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Frostburg, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>M. J. [Signature]</u>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <u>AUG 7 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. [Signature]</u>	

CERTIFICATE OF DEATH

WILLIAM  
JAMES  
BROWN

Name of Deceased		WILLIAM JAMES BROWN	
Age		61	
Sex		Male	
Race		White	
Date of Death		July 12, 1911	
Place of Death		Home	
Cause of Death		Heart Failure	
Disease		Hypertension	
Occupation		Retired	
Residence		123 Main St, Baltimore, Md.	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	
Date of Registration		July 15, 1911	
Place of Registration		Baltimore, Md.	

9104

## CERTIFICATE OF DEATH

09097

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>Since 8-10-59</b> x <b>Point of Rocks</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Frederick Memorial Hospital</b>		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>NONA</b> Middle <b>HUERKY</b> Last <b>SIGAFOOSE</b>		4. DATE OF DEATH Month <b>August</b> Day <b>16</b> , Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 29, 1881</b>
9. AGE (In years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months <b>77</b> Days <b>16</b> Hours <b>19</b> Min.	IF UNDER 24 HRS. Months <b>77</b> Days <b>16</b> Hours <b>19</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles W. Wright</b>		14. MOTHER'S MAIDEN NAME <b>Mary Jane Brown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>	
17. INFORMANT <b>Miss Ocale C. Wright- Same as Item #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral infarction</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b> <b>1 year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8-15</b> , 19 <b>59</b> , to <b>8-16</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>8-15</b> , 19 <b>59</b> , and that death occurred at <b>7:10A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Medical Center</b> DATE SIGNED <b>8/16/59</b> ACTUAL SIGNATURE <b>Rex R. Martin</b> M.D. <b>Frederick, Maryland</b> PHYSICIAN'S NAME (Type) <b>Rex R. Martin, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 19, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Paul's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Point of Rocks, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 20 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Haves</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

9133

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09098

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Route #c15		c. LENGTH OF STAY IN 1b Minutes	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 099 Enroute to Frederick Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Howard Middle Blaine Last Smith		4. DATE OF DEATH Month August 2 Year 19 59	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-24-1882
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Smith		14. MOTHER'S MAIDEN NAME Emma C. Rush	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-12-1803	
17. INFORMANT Mrs. Morris Eby		Address Rocky Ridge, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 12 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE B. O. Thomas		DATE SIGNED	
EXAMINER'S NAME (Type) B.O. Thomas		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-5-59	
22c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery		22d. LOCATION (City, town, or county) (State) Woodsboro, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager		ADDRESS Thurmont, Md.	
24a. REC'D BY REGISTRAR DATE AUG 5 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



14. 11. 1950

1-10-1944

2001-2005

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 20 Film 248 9-3-59 ams

09099

9134

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>FREDERICK</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KEYMAR RURAL</u>		c. LENGTH OF STAY IN 1b <u>YEARS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>LAURA</u> Middle <u>CATHERINE</u> Last <u>SMITH</u>		4. DATE OF DEATH Month <u>AUG</u> Day <u>26</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/21/1863</u>
9. AGE (In years last birthday) <u>96</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NURSE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NURSE</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>PETER SMITH</u>		14. MOTHER'S MAIDEN NAME <u>MARY BALDEN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MRS WM WILHELM</u>		Address <u>KEYMAR RURAL MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>903.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fracture left femur</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture left femur</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>3 weeks</u>	
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell while walking in bedroom fracturing femur</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>7</u> <u>7-28</u> <u>1959</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>nr. Ladiesburg Frederick Md</u>	
21. I certify that I attended the deceased from <u>1 August</u> , 19 <u>59</u> , to <u>26 Aug.</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>25 August</u> , 19 <u>59</u> , and that death occurred at <u>1:15 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James E. Stoner Jr.</u> M.D.		DATE SIGNED <u>Walhersville, Md 8/27/59</u>	
PHYSICIAN'S NAME (Type) <u>JAMES E STONER JR</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>AUG-28-1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>BEAVER DAM</u>		22d. LOCATION (City, town, or county) (State) <u>FREDERICK CO MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Hartzler &amp; Sons</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 31 '59</u>	
ADDRESS <u>Union Bridge Md</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kinn</u>	

CERTIFICATE OF DEATH

9134

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		65		M		W		JAN 15 1888		BALTIMORE, MD.	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		NAME OF SPOUSE		DATE OF DEATH		PLACE OF DEATH	
MARRIED		JUN 15 1910		BALTIMORE, MD.		JANE HARRIS		JAN 15 1910		BALTIMORE, MD.	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		SOCIETY	
HEART DISEASE		NATURAL		LABORER		HIGH SCHOOL		METHODIST		BALTIMORE	
DATE OF DEATH		PLACE OF DEATH		NAME OF PHYSICIAN		NAME OF HOSPITAL		NAME OF NURSE		NAME OF BURIAL PLACE	
JAN 15 1910		BALTIMORE, MD.		J. H. HARRIS		BALTIMORE HOSPITAL		J. H. HARRIS		BALTIMORE CEMETERY	
SIGNATURE OF PHYSICIAN		SIGNATURE OF HOSPITAL		SIGNATURE OF NURSE		SIGNATURE OF BURIAL PLACE		SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES	
J. H. HARRIS		BALTIMORE HOSPITAL		J. H. HARRIS		BALTIMORE CEMETERY		J. H. HARRIS		J. H. HARRIS	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME  
5M 2/57

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
9105 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09100

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>Years</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		d. STREET ADDRESS <b>30-A East Fourth Street</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>DOA Frederick Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>HENRY</b> Last <b>SOUDER</b>		4. DATE OF DEATH Month <b>August</b> Day <b>9</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1 Dec 1895</b>
9. AGE (in years last birthday) <b>63</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bus Company</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13. FATHER'S NAME <b>George C. Souder</b>	
14. MOTHER'S MAIDEN NAME <b>Charlotte H. Grimes</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> <b>WWI</b>	
16. SOCIAL SECURITY NO. <b>214-10-4149</b>		17. INFORMANT <b>Mrs. M. Helen Souder (Same as item #2)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>420.1</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>B. O. Thomas</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>B. O. Thomas, M. D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>11 Aug 1959</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8-12-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		24a. REC'D BY REGISTRAR <b>DAUG 13 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9106

## CERTIFICATE OF DEATH

Reg. Dist. No.

09101

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>2 weeks</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Orville W. Stackhouse</b>		4. DATE OF DEATH Month <b>August</b> Day <b>11</b> Year <b>1959</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 16, 1919</b>
9. AGE (In years last birthday) <b>39</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Attendant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gas Station</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Carl Stackhouse</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Shaffer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, never unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>214-16-1810</b>	
17. INFORMANT <b>Thelma Y. Stackhouse</b>		Address <b>Thurmont, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatous</b> <b>155.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Adenocarcinoma of the gall bladder</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bronchopneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 mo</b> <b>1 mo +</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7/27</b> , 19 <b>59</b> , to <b>8/11</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>8/11</b> , 19 <b>59</b> , and that death occurred at <b>10:30 A</b> .M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4 E. Church St</b> DATE SIGNED <b>8/11/59</b>			
ACTUAL SIGNATURE <b>Henry V. Chase</b>		M.D. <b>Frederick Maryland</b>	
PHYSICIAN'S NAME (Type) <b>Henry V. Chase</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-14-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>United Brethern Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Thurmont, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Creager</b>		ADDRESS <b>Thurmont, Md.</b>	
24a. REC'D BY REGISTRAR <b>DATE AUG 17 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

CERTIFICATE OF DEATH

2100

DECEASED [Name]		SEX Male		AGE 30	
RACE White		BIRTH 1910		PLACE OF BIRTH [Location]	
OCCUPATION [Occupation]		CAUSE OF DEATH [Cause]		MANNER OF DEATH [Manner]	
DATE OF DEATH [Date]		TIME OF DEATH [Time]		PLACE OF DEATH [Place]	
SIGNATURE OF DECEASED [Signature]		SIGNATURE OF WITNESS [Signature]		SIGNATURE OF PHYSICIAN [Signature]	
SIGNATURE OF CLERK [Signature]		SIGNATURE OF JUDGE [Signature]		SIGNATURE OF SHERIFF [Signature]	

# 9135 CERTIFICATE OF DEATH

09102

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt Airy Md RD#5</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Mt Airy RD#3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ESTHER</u> First <u>MAE</u> Middle <u>TAYLOR</u> Last		4. DATE OF DEATH <u>Aug - 4</u> Month <u>1959</u> Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 28, 1893</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Brownsville Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William A. Walker</u>		14. MOTHER'S MAIDEN NAME <u>Laura A. Day</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Mr Wm A. Taylor, Mt Airy, Md RD#3</u>	
17. INFORMANT <u>Mr Wm A. Taylor, Mt Airy, Md RD#3</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Thrombosis</u> <u>900.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Shock due to fall down steps</u> DUE TO (c) <u>Sudden</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Accidentally fell down stairs in home. Fracture of 2-3 ribs post</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>2</u> p.m. <u>8-2-59</u> 19	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>at home</u>	20f. (City or town) (County) (State) <u>RD Mt Airy Fred Md</u>
21. I certify that I attended the deceased from <u>Aug 3, 1959</u> , to <u>Aug 4, 1959</u> , that I last saw the deceased alive on <u>Aug 3, 1959</u> , and that death occurred at <u>2 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C M Voss Poole</u> M.D.		DATE SIGNED <u>8-4-59</u>	
PHYSICIAN'S NAME (Type) <u>C M Voss Poole</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug 6-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bethesda Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Brownsville, Montgo Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. S. Myers Jr</u>		24a. REC'D BY REGISTRAR <u>Westminster Md</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>

MEDICAL CERTIFICATION

10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9107

## CERTIFICATE OF DEATH

09103

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>Years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>316 Rockwell Terrace</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>EDWARD</b> Middle <b>PHILIP</b> Last <b>THOMAS</b>				4. DATE OF DEATH Month <b>August</b> Day <b>25</b> , Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 26, 1892</b>		9. AGE (In years last birthday) <b>67</b> yrs.	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Doctor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Surgery</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Newton L. Thomas</b>				14. MOTHER'S MAIDEN NAME <b>Sue Mathias</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT <b>Mrs. Louise G. Thomas—Same as Item #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro-Vascular Accident</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive arteriosclerotic Heart disease</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>years.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5:30 PM 8/25 1959</b> to <b>8:30 PM 8/25 1959</b> , that I last saw the deceased alive on <b>8/25</b> 19 <b>59</b> , and that death occurred at <b>8:30 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>R. C. Reynolds, M.D.</b>				ADDRESS (Street, city or town, state) <b>East Church Street</b> DATE SIGNED <b>8/27/59</b>			
PHYSICIAN'S NAME (Type) <b>R. C. Reynolds, M.D.</b>				Frederick, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 28, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				ADDRESS <b>Frederick, Maryland</b>		24a. REC'D BY REGISTRAR <b>Aug 28 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Charles E. Hines</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page.

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove corbion papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1. *Agrostis capillaris* L.  
 2. *Poa annua* L.  
 3. *Trisetum flavescens* (L.) Ga.  
 4. *Hordeum jubatum* L.  
 5. *Elymus canadensis* L.  
 6. *Setaria viridis* (L.) Ga.  
 7. *Digitaria sanguinalis* (L.) Scop.  
 8. *Eleusine indica* (L.) Ga.  
 9. *Phalaris minor* (L.) Ga.  
 10. *Briza media* (L.) Ga.  
 11. *Lolium perenne* (L.) Ga.  
 12. *Cynodon dactylon* (L.) Pers.  
 13. *Styria arvensis* (L.) Ga.  
 14. *Andropogon scoparius* (L.) Mill.  
 15. *Sorghum arvense* (L.) Ga.  
 16. *Tripsacum dactyloides* (L.) Ga.  
 17. *Chenopodium album* (L.) Ga.  
 18. *Amaranthus retrofractus* (L.) Ga.  
 19. *Rumex crispus* (L.) Ga.  
 20. *Portulaca oleraceae* (L.) Ga.  
 21. *Portulaca quadrifida* (L.) Ga.  
 22. *Portulaca littoralis* (L.) Ga.  
 23. *Portulaca perfoliata* (L.) Ga.  
 24. *Portulaca zosterifolia* (L.) Ga.  
 25. *Portulaca virginica* (L.) Ga.  
 26. *Portulaca americana* (L.) Ga.  
 27. *Portulaca pilosa* (L.) Ga.  
 28. *Portulaca ananensis* (L.) Ga.  
 29. *Portulaca oleraceae* (L.) Ga.  
 30. *Portulaca quadrifida* (L.) Ga.  
 31. *Portulaca littoralis* (L.) Ga.  
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 45. *Portulaca pilosa* (L.) Ga.  
 46. *Portulaca ananensis* (L.) Ga.  
 47. *Portulaca oleraceae* (L.) Ga.  
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 50. *Portulaca perfoliata* (L.) Ga.  
 51. *Portulaca zosterifolia* (L.) Ga.  
 52. *Portulaca virginica* (L.) Ga.  
 53. *Portulaca americana* (L.) Ga.  
 54. *Portulaca pilosa* (L.) Ga.  
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 58. *Portulaca littoralis* (L.) Ga.  
 59. *Portulaca perfoliata* (L.) Ga.  
 60. *Portulaca zosterifolia* (L.) Ga.  
 61. *Portulaca virginica* (L.) Ga.  
 62. *Portulaca americana* (L.) Ga.  
 63. *Portulaca pilosa* (L.) Ga.  
 64. *Portulaca ananensis* (L.) Ga.  
 65. *Portulaca oleraceae* (L.) Ga.  
 66. *Portulaca quadrifida* (L.) Ga.  
 67. *Portulaca littoralis* (L.) Ga.  
 68. *Portulaca perfoliata* (L.) Ga.  
 69. *Portulaca zosterifolia* (L.) Ga.  
 70. *Portulaca virginica* (L.) Ga.  
 71. *Portulaca americana* (L.) Ga.  
 72. *Portulaca pilosa* (L.) Ga.  
 73. *Portulaca ananensis* (L.) Ga.  
 74. *Portulaca oleraceae* (L.) Ga.  
 75. *Portulaca quadrifida* (L.) Ga.  
 76. *Portulaca littoralis* (L.) Ga.  
 77. *Portulaca perfoliata* (L.) Ga.  
 78. *Portulaca zosterifolia* (L.) Ga.  
 79. *Portulaca virginica* (L.) Ga.  
 80. *Portulaca americana* (L.) Ga.  
 81. *Portulaca pilosa* (L.) Ga.  
 82. *Portulaca ananensis* (L.) Ga.  
 83. *Portulaca oleraceae* (L.) Ga.  
 84. *Portulaca quadrifida* (L.) Ga.  
 85. *Portulaca littoralis* (L.) Ga.  
 86. *Portulaca perfoliata* (L.) Ga.  
 87. *Portulaca zosterifolia* (L.) Ga.  
 88. *Portulaca virginica* (L.) Ga.  
 89. *Portulaca americana* (L.) Ga.  
 90. *Portulaca pilosa* (L.) Ga.  
 91. *Portulaca ananensis* (L.) Ga.  
 92. *Portulaca oleraceae* (L.) Ga.  
 93. *Portulaca quadrifida* (L.) Ga.  
 94. *Portulaca littoralis* (L.) Ga.  
 95. *Portulaca perfoliata* (L.) Ga.  
 96. *Portulaca zosterifolia* (L.) Ga.  
 97. *Portulaca virginica* (L.) Ga.  
 98. *Portulaca americana* (L.) Ga.  
 99. *Portulaca pilosa* (L.) Ga.  
 100. *Portulaca ananensis* (L.) Ga.

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Page 10

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME  
BMA 2/57

9108

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09104

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>4 Hrs. &amp; 50 Min.</b> <input checked="" type="checkbox"/> <b>Buckeystown</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Frederick Memorial Hospital</b>		d. STREET ADDRESS <b>7</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>HARRY</b> Middle <b>IRVIN</b> Last <b>TROUT</b>		4. DATE OF DEATH Month <b>August</b> Day <b>22</b> , Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>27 Oct 1914</b>
9. AGE (In years last birthday) <b>44</b> yrs.		IF UNDER 1 YEAR Months <b></b> Days <b></b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cost &amp; Payroll Dept.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Everedy Company</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>George W. Trout</b>		14. MOTHER'S MAIDEN NAME <b>Lillie Jane Ricketts</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-10-2943</b>	
17. INFORMANT <b>George W. Trout</b>		Address <b>(Same as item #2)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gunshot Wound of Head</b> <b>976x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b></b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 Hours &amp; 50 Minutes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>Gunshot Wound of Head with revolver</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Gunshot Wound of Head with revolver</b>	
20c. TIME OF INJURY Month, Day, Year <b>3</b> Hour <b>XXXX</b> <b>8-22, 1959</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Public Highway</b>		20f. (City or town) (County) (State) <b>Nr. Buckeystown-Frederick, Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>B. O. Thomas</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>B. O. Thomas, M. D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <b>24 Aug 1959</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-26-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		ADDRESS <b>Frederick, Maryland</b>	
24a. REC'D BY REGISTRAR <b>DATE AUG 25 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Orlino S. Kenna</b>	



9136

## CERTIFICATE OF DEATH

09105

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Emmitsburg rural</b>		c. LENGTH OF STAY IN 1b <b>50 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Helen Missouri Valentine</b>		4. DATE OF DEATH Month <b>August</b> Day <b>15</b> Year <b>1959</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 5, 1865</b>
9. AGE (In years last birthday) <b>94</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		12. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
13. BIRTHPLACE (State or foreign country) <b>Maryland</b>		14. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. FATHER'S NAME <b>John Ohler</b>		16. MOTHER'S MAIDEN NAME <b>Annie Shorb</b>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		18. SOCIAL SECURITY NO. <b>None</b>	
19. INFORMANT <b>Emory Valentine</b>		20. ADDRESS <b>Emmitsburg, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>422.1</b> IMMEDIATE CAUSE (a) <b>arteriosclerotic cardiac vas disease present years</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Lymph. sarcoma neck &amp; metastases</b> INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 30</b> to <b>Aug 15 59</b> , that I last saw the deceased alive on <b>Aug 14</b> , 19 <b>59</b> and that death occurred at <b>10:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Emmitsburg, Md</b> DATE SIGNED <b>8-17-59</b> ACTUAL SIGNATURE <b>W.R. Cadle</b> M.D. <b>Emmitsburg, Md</b> PHYSICIAN'S NAME (Type) <b>W.R. Cadle</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-18-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Tabor Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Rocky Ridge, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Creager</b>		24a. REC'D BY REGISTRAR <b>AUG 20 '59</b>	
ADDRESS <b>Thurmont, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

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Page 4 death. The law requires that the death certificate be executed within 24 hours of death. Pages 1 and 2 should be filled with the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Pages 1 and 2 should be filled with the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

9136

CERTIFICATE OF DEATH

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9137

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick-Rural RD#6</b>				c. LENGTH OF STAY IN 1b <b>29 Years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Quinn Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>LEWIS</b> Last <b>WACHTER</b>				4. DATE OF DEATH Month <b>August</b> Day <b>22</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>18 May 1890</b>	
9. AGE (In years last birthday) yrs. <b>69</b>		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Farm Owner</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Granville L. Wachter</b>				14. MOTHER'S MAIDEN NAME <b>Florence V. Stup</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>215-36-6904</b>			
17. INFORMANT <b>Mrs. Ella S. Wachter (Same as item #1)</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardiovascular disease</b> DUE TO (c) <b>27 yrs +</b> INTERVAL BETWEEN ONSET AND DEATH <b>10 minutes</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Jan 2, 1952</b> to <b>Aug 22, 1959</b> that I last saw the deceased alive on <b>Aug 19, 1959</b> , and that death occurred at <b>4 A M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>228 N. Market St. Frederick, Md.</b> DATE SIGNED <b>24 Aug 1959</b>							
ACTUAL SIGNATURE <b>B. O. Thomas</b>				M.D. <b>Frederick, Md.</b>			
PHYSICIAN'S NAME (Type) <b>B. O. Thomas, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-25-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				ADDRESS <b>Frederick, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 25 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2137

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9109

CERTIFICATE OF DEATH

Reg. Dist. No.

09107

1. PLACE OF DEATH o. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>	c. LENGTH OF STAY IN 1b <u>50 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>11 Frederick</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>19 East Patrick ST</u>		d. STREET ADDRESS <u>19 East Patrick ST</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>William</u> <u>RAYMOND</u> <u>WALTER</u>		4. DATE OF DEATH Month Day Year <u>Aug</u> <u>14</u> <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 22 1909</u>
9. AGE (In years last birthday) <u>57</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ENGINEER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>City of Frederick</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>ALBERT W. WALTER</u>		14. MOTHER'S MAIDEN NAME <u>DAISY CRIM</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-18-1909</u>	
17. INFORMANT <u>C. EDWARD WALTER</u>		Address <u>BALTIMORE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary occlusion</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart disease</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>5-10 min</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April</u> , 19 <u>55</u> , to <u>August</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Aug 4</u> , 19 <u>59</u> , and that death occurred at <u>6 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Henry V. Chase</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>4 E. Church St</u> <u>8/14/59</u>	
PHYSICIAN'S NAME (Type) <u>Henry V. Chase</u>		<u>Frederick, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>8/17/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MT CHURCH</u>	22d. LOCATION (City, town, or county) (State) <u>Frederick Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kelvin G. Barty</u>		ADDRESS <u>Frederick, Md</u>	
24a. REC'D BY REGISTRAR DATE <u>AUG 18 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kline</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

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VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
9138 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 11 Film G247 8-28-59 et

09108

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Braddock Heights		c. LENGTH OF STAY IN 1b Hour	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pond-Strawsleigh Development		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural- R.F.D.#4	
3. NAME OF DECEASED (Type or print) First ALVEY Middle DOUB Last YOUNG, JR.		4. DATE OF DEATH Month August Day 16, Year 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH September 5, 1933
9. AGE (In years last birthday) 25 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Maryland Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Alvey Doub Young, Sr.		14. MOTHER'S MAIDEN NAME Leah Lark	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No No		16. SOCIAL SECURITY NO. 214-36-1070	
17. INFORMANT Mrs. Alvey D. Young, Sr.		Address Same as Item #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DROWNING 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.) Drowned in Pond on Development	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Strawby's Lake		20f. (City or town) Braddock Hgts (County) Fred. (State) Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE B. O. Thomas		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) B. O. Thomas, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 8/18/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 20, 1959	
22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick, (State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE	
DATE AUG 20 '59		Orlwin E. Hines	



1933  
MAYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Manner of Death	
John Doe		Male		45		Jan 1, 1888		New York City		123 Main St		Heart Disease		Natural	
Occupation		Education		Marital Status		Previous Illnesses		Last Illness		Time of Death		Place of Death		Signature of Examiner	
Teacher		High School		Married		Hypertension		Chest Pain		Jan 15, 1933		Home		[Signature]	
Signature of Physician		Signature of Coroner		Signature of Medical Examiner		Signature of Registrar		Signature of Burial Officer		Signature of Undertaker		Signature of Funeral Home		Signature of Cemetery	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**9110**  
**CERTIFICATE OF DEATH**

09109

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>50 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wynelle Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>CURTIS THOMAS ZIMMERMAN</b>		4. DATE OF DEATH Month Day Year <b>August 16, 1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 13, 1864</b>
9. AGE (In years last birthday) <b>94</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Peter T. Zimmerman</b>		14. MOTHER'S MAIDEN NAME <b>Ann Maria Cronise</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Mamie C. Arnold, Lucketts, Virginia</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO (b) <b>Nephrosclerosis</b> DUE TO (c) <b>446x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <b>Month</b> <b>Year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8/16</b> , 19 <b>59</b> , to <b>8/16</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>8/16</b> , 19 <b>59</b> , and that death occurred at <b>4:45 A. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James B. Thomas</b>		ADDRESS (Street, city or town, state) <b>Professional Building</b>	
PHYSICIAN'S NAME (Type) <b>James B. Thomas, M.D.</b>		DATE SIGNED <b>8/18/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 19, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		24a. REC'D BY REGISTRAR <b>AUG 24 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. K...</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

9110

SEE OTHER

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		Male		35		1875		BALTIMORE, MARYLAND	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		PLACE OF DEATH	
Carpenter		Heart Disease		Natural		Several Weeks		Home	
DATE OF DEATH		TIME OF DEATH		TEMPERATURE		PULSE		RESPIRATION	
April 10, 1910		10:30 AM		101.0		90		20	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEAREST RELATIVE	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
April 10, 1910		April 10, 1910		April 10, 1910		April 10, 1910		April 10, 1910	